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PATIENTS' EXPERIENCES AND SOCIAL RELATIONS
IN GERIATRIC WARDS
(TWO VOLUMES)

VOLUME I

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PATIENTS' EXPERIENCES AND SOCIAL RELATIONS IN GERIATRIC WARDS

SUMMARY

This thesis is based on research which aimed to describe and account for patients' experiences in eight unexceptional examples of predominantly long-stay geriatric wards, each in a different hospital.

Observational methods were used to document the experiences of 86 patients. Other data on ward work processes were drawn from interviews with Ward Sisters and Consultants, written records and informal conversations with ward participants. Data analysis was based on the type and amount of inhumane treatment which patients suffered. In focussing on inhumane treatment and developing a systematic and non-emotive analysis of its origins, the research breaks new ground.

Patients in all the wards experienced inhumane treatment, but this varied in kind and quantity. It is shown that poor staffing levels and heavy workload cannot by themselves account for the inhumane treatment of patients which was observed. Instead, the beliefs, work practices and interrelationships between Consultants and Ward Sisters emerged as important. Where the work of long-term care was viewed as a valuable and important task, there was evidence of attempts to offer personalised care to patients. Where long-term care was viewed as low-status work, an outcome of 'failure' of the medical cure system, there was scant evidence of personal attention to patients' needs.

The nature of inhumane treatment which was observed enables a new perspective to be offered on what constitutes humane treatment and how this might be reliably secured in practice. Eight practical recommendations are made on the basis of research findings. Consideration is also given to ways in which the innovatory social research approach of documenting inhumane treatment might be further developed and applied in practice by professionals seeking to monitor and improve patients' experiences in geriatric wards.

CHAPTER ONE

INTRODUCTION

This thesis is based on research which aimed to describe and account for patients' experiences in eight predominantly long-stay geriatric wards. The literature offers a variety of descriptions and analyses of the problems of geriatric care. Yet much remains to be done, conceptually and practically, in developing and implementing models of providing long-stay institutional geriatric services. The contribution of this thesis is to demonstrate the potential of a particular social research approach which takes patients' experiences as central.

Background to the project

My research had its roots in an earlier project commissioned by a large District General Hospital. The focus was on how nurses might be better utilised in hospital wards. Management couched the problem in terms of styles of organising nursing work in wards; and nurses' satisfaction with their day-to-day work experience. The project was carried out in the ethos of an important contemporary belief system: that the Holy Grail of 'quality patient care' was to be found by managerially-orientated research which defined, specified and measured patients' 'ideal' nursing care requirements, through using patient-nurse dependency measures. Having achieved this, it was seen as a simple administrative task to define required numbers and grades of nursing staff; and as a more complex, but feasible, task to allocate scarce nursing resources equitably among the wards of the hospital.¹

¹The currency of this approach has now diminished, contingent upon the more sophisticated view of nursing embodied in the philosophy of 'The Nursing Process', which was beginning to be imported from North America in the early and middle 1970s. But even in 1984 many members of the nursing profession are still prone to attribute all problems of nursing care to shortages of staff.

It was in this kind of climate that I observed the nurses of four wards, each of a different specialty, at work; and interviewed them about their views on the quality of care they were helping to provide, and their own satisfaction and dissatisfaction . The study showed that staffing levels bore a rather complicated relationship to how the nurses perceived ward 'effectiveness'. It was not so much actual numbers that were important, but numbers in relation to what nurses were used to. Relative feast-days posed just as many 'problems' for running the ward as did days of famine. The way that ward sisters organised work emerged as important, as also did the extent to which the work of the various professionals was integrated in practice. So-called 'personality factors' operating in ward 'teams' seemed explicable in terms of the organisation of social relations among patient care staff (Evers, 1977a,1977b).

Because my research was based on a managerial brief, I did not attempt to look at patients' experiences in the different wards, and how they might be affected by differing patterns of social relations. This was, of course, a most serious and mistaken omission.

Thus the agenda for my new research was to address this fundamental question: are there real differences for patients in different wards, and, if so, are these differences related to work processes and to social relations among the participants in ward work? Tackling this question is an important prerequisite to identifying particular configurations of social relations which are likely to improve patients' experiences; and understanding how to disseminate these in practice.

I chose to carry out the research in the geriatric specialty for two reasons. First, geriatrics is commonly regarded as a low technology

specialty. Thus it seemed reasonable to assume there could be a wide variety in terms of social organisation, and thus a rich arena for researching patients' experiences in the context of ward social relations. Second, contemporary demographic and political pressures to review the whole spectrum of services for elderly people suggested to me that hospital geriatric care was one area in which innovation and change were real possibilities. As I hoped the research might make practical as well as academic contributions, I became particularly attracted to geriatrics.

I found the research process depressing and upsetting. Rather than discounting my feelings, I examined them and concluded that they derived not simply from being in wards with a high proportion of dependent, frail old people with poor future prospects, but also from the distressing way in which some of the patients experienced the service, their treatment adding to their suffering.

It was for these reasons that I decided to focus my work systematically on the patients' negative experiences and to analyse these, hoping thereby neither to avoid the issue of the difficulties I saw, nor to emerge with merely an emotive account of my results. The focus on patients' negative experiences was a preliminary to formulating ground rules for changes which will address some of the root causes of patients' suffering as a direct result of their hospitalisation. So far as I am aware, there are no studies which dispassionately and systematically analyse the inhumane treatment experienced by patients in unexceptional examples of geriatric institutions, known neither for their excellence nor for their atrocities.

A study of the kind described in this thesis is needed because of perennial concern about standards in long-stay geriatric care. Most

professionals have opinions about 'quality' patient care, and much research has been devoted to this. But it apparently remains impossible to reach consensus about ideals and how to achieve them in a world of practical constraints. However, it is often much easier to agree about concrete instances of unacceptable standards. Concentrating on the negative may seem to be only the other side of the 'quality' coin. But social research methods which identify some negative aspects of present-day practices as they affect patients, and the antecedents of these, may obviate the difficulties of defining high quality patient care. They may offer an alternative route to conceptualising and realising a better future for patients, those who look after them and those who love them. The specific contributions derived from my research on inhumanity towards patients are to:

1. Point to some of the root causes of inhumane treatment;
2. Highlight what constitutes humane care;
3. Outline the steps needed if humane care is to be more widely practised;
4. Offer the beginnings of a simple research and development tool which could be taken up by professionals concerned with monitoring and improving the practices of their own long-stay geriatric wards.

A guide to the thesis

Chapter Two reviews the literature. I begin by showing that geriatric patients differ in certain respects from other categories of hospital patient, and thus studies specifically of geriatric care have the most bearing on my own research. I shall show that many such studies have produced depressing findings, yet can be found wanting when it comes to developing improved models of care. I discuss the reports of official

inquiries into institutional atrocities of the 1960s and 1970s, and argue that non-emotive analysis of the negative aspects of care in 'ordinary' institutions comprises a neglected approach in social research; an approach which holds great promise both for understanding how patients' experiences are affected by institutional relations, and for developing improved models of care organisations. One study I found particularly valuable is of institutional care for physically handicapped people: that of Miller and Gwynne (1972). I outline their 'Warehousing' and 'Horticultural' models of care. The former proves useful in discussing my own findings.

Chapter Three describes the research methods. Patients' experiences are central, and much of the analysis is based on data from observing patients. The 'inhumanity index', which is applied to patient-centred observations, is explained. I observed 86 patients from eight wards in different hospitals, representative of the average kind of long-stay geriatric wards to be found in any region of the U.K.

Chapter Four begins the data analysis by presenting the findings from two wards, Cranford and Bramlington.¹ The nature and amount of inhumane treatment is discussed in the context of what I observed of ward sisters' and consultants' work practices, and what they said about their work in interviews, as well as ward staffing levels. Cranford exemplifies, after Miller and Gwynne, 'personal warehousing': work organised by routines, with some evidence of attention to patients as individuals. Yet there is considerable evidence of inhumane treatment. Bramlington is a 'minimal warehousing' ward: there is no evidence to speak of that patients are treated as individuals; the pervasive basic

¹Pseudonyms have been used for all hospitals, wards, staff, patients and others.

routines often fail even to accomplish fundamental physical care; there is evidence that patients suffer inhumane treatment. It does not seem that poor staffing levels alone can account for these findings.

Chapter Five contains four more ward case studies. The analysis begins to show that ward sisters' and consultants' beliefs and practices, and their work inter-relationships are very important in understanding the nature and amount of inhumane treatment which patients experience. The defining characteristics of 'personal' and 'minimal' warehousing wards are set out.

Chapter Six discusses the last two wards. These were deviant cases: District Ward featured much acute work; Heathlands was an experiment in improving long-term life in hospital for severely disabled but mentally alert patients. The findings from these two wards clarify the analysis further, and show, as do some of the case studies of Chapter 5, that patients who 'fit in' with the type of care regime a ward is geared to produce, suffer less inhumane treatment than 'misfit' patients. Again, the findings can be made sense of in the context of ward sisters' and consultants' beliefs and work practices, and their work relationships. Staffing levels in relation to workload can now be shown to account for very little when it comes to understanding the antecedents of patients' inhumane treatment.

Chapter Seven summarises the findings from the eight case studies, and identifies some cross-cutting themes: differing types of patient-care goals, the philosophy and practice of multi-disciplinary teamwork in geriatric care, and gender: it emerged that the preponderance of women, both as patients and staff, was not without significance regarding patients' experiences in hospital.

Chapter Eight, the last chapter, ends the thesis on a very positive note. First, I discuss the nature of humane treatment and review evidence of it in the eight study wards. Second, I set out eight very specific recommendations on the basis of my research findings. Last, I discuss the possibilities for further development of the 'inhumanity index' as a practical tool for professionals to use in their efforts to review and if necessary bring about ameliorative changes in the long-stay care settings for which they are responsible.

CHAPTER TWO

REVIEW OF THE LITERATURE

My immediate research problem was to describe, evaluate and account for patients' experiences in predominantly long-stay geriatric wards. My less immediate, but overarching interest, was attempting to contribute to research-based development of changed models of care which might improve the kinds of experiences geriatric patients undergo in hospital.

Are Geriatric Patients Really Different?

In developing the conceptual and methodological bases of my study, an early question was the extent to which I could draw on the sociological literature about hospital patient care, and apply it to geriatric patients. A central issue seemed to me to be whether I could assume that elderly patients were equivalent to other categories of patient, whose experiences of hospital care have been studied and reported in the literature. There are two ways of looking at this. First, is the organisational structure for hospital care of geriatric patients the same as that for other categories of hospital patient? Second, and following on from this, is the social position of geriatric patients equivalent to that of other categories of patient?

Organisational Structure of Geriatric Hospital Care

Elderly patients occupy about half of all acute non-psychiatric, geriatric beds (DHSS, 1981). For example, in 1980, 57% of medical patients over 65 years old were treated in general medical beds (DHSS, 1982). However, 43% of medical patients over the age of 65 are looked after in geriatric beds under the care of physicians in geriatric medicine

(DHSS, 1982). Ninety-six percent of geriatric beds are occupied by people over 65 years old; those of 75 years occupy 73% of geriatric beds (DHSS, 1981). There are variations as to the details of the organisation of geriatric departments and criteria for admission (see Silver, 1977, Horrocks, 1982, Irvine, 1983 for helpful descriptions of these) but a shared feature of all is that they cater for a patient category defined first and foremost by chronological age: geriatrics is the specialty of the very old. Paediatrics alone among medical specialties shares with geriatrics a primarily age-defined patient population. Thus modern geriatrics features the application of an extremely broad base of medical knowledge to a medically heterogeneous patient population. It also features emphasis on a wide range of rehabilitative measures: indeed, expertise in rehabilitation forms, as Fairhurst points out, an important part of the argument that geriatrics constitutes a distinctive medical specialty (Fairhurst, 1981). The organisation of medical knowledge around an age-defined patient category rather than disease- or bodily system-defined categories suggests that there may be important differences between a specialty like geriatrics as compared with other specialties regarding the organisation of hospital patients' medical care. Therefore geriatric patients cannot be regarded as equivalent to other patient categories. But what about paediatrics? It too is an age-defined specialty, so to what extent are researches into hospital care of paediatric patients relevant to my research concerns?

Social Position of Old People and Children

Children, like many elderly people, are economically non-productive members of society. They are dependants. But so far as other features of the social positions of children and the elderly go, they probably

have very little in common. Children have potential: they are future wage earners, supporters and carers of families, reproducers of the labour force, and so on. None of this is true for elderly people. While much of the dependency and decline commonly seen to inhere in the very category 'old' may be socially constructed (see for example Phillipson, 1982; Walker, 1980) the net result is that we cannot assume that there is much in the way of common ground between the way that child patients and geriatric patients are construed, and their care defined and organised, under the auspices of the two age-defined specialties of paediatrics and geriatrics.

Thus, looking at both organisation of medical care in relation to geriatric patients and social position of old people, the answer to my simplistic question, 'Are geriatric patients different from other categories?' is, probably 'Yes'. In my research, then, I decided that it would be appropriate to focus on the literature specifically relating to old people and institutional care, in particular, British literature. The literature from overseas, most importantly North America and Europe, has been reviewed elsewhere (see for example Kane and Kane, 1976; Amman, 1980). Its relevance to my research problem is less immediate than that of the British literature, since the detailed arrangements for organising care systems which shape the experiences of elderly patients are highly culture-bound and inextricably linked with the wider political systems of different countries, as has been pointed out elsewhere (e.g. Baker, 1978). Since I am not reporting an international comparative study, but one located in the British system, I shall not review the literature from overseas.

Institutional Care of Old People

Writing in 1949, Thomson prefaces his studies of the problems of ageing and chronic sickness with comments on his first impressions of the hospital from which the studies were done:

"My most vivid impression of the chronic wards ... is of an atmosphere of profound apathy. The patients seldom spoke to each other; they rarely moved, and ... it was exceptional to see one reading. Contact with the patients was not difficult; histories of their social background and infirmities were ... readily given, but what made them remarkable was the conspicuous absence of emotional overtones as they recounted them. ... One old lady told us a strange story of many years of colourful life breeding and breaking ponies in the Welsh Marches, ... of independent freedom rarely to be attained in England now. ... Her face was immobile as she spoke; the glory and the zest had departed; she was interested mainly in her tea, which was a little late. Food, indeed, was their major interest; ... The wards came momentarily to life at meal-times." (Thomson et al., 1951:15)

Later, Thomson praises the standards of physical care provided by nurses working in appalling circumstances:

"Two nurses were on duty in wards containing seventy patients, of whom thirty were incontinent; they never stopped working - they did not come to speak to the doctor of the ward or to the matron unless they were sent for; quietly and efficiently they went on with their job" (1951:18)

Thomson describes the 'lamentable' conditions under which patients were cared for, and, in praising the nurses' dedication and deploring the paucity of resources devoted to the care of the chronic sick, Thomson remarks:

"Rivers of ink have already flowed into the sterile sands of controversy about the nursing problem ... (1951:19)

While it could, thirty-five years on, be suggested that care of the elderly has been revolutionised, it is significant that Thomson's sense of shock vis à vis institutionalisation of patients, overworked nurses and

inadequate resources continues to find echoes today. For example, writing in 1983, Denham (p.12) says of long-stay geriatric wards:

"In spite of upgrading, these wards can still look depressing, lack privacy for the patient, are often noisy and may smell of urine. The patients may be dressed in clothing which is not their own, and sit in rows along the wall, staring vacantly into space and doing nothing ... In such an establishment, where staff may consider there is nothing further to be done, institutionalisation can rapidly develop".

What has the literature to offer in terms of describing and analysing the processes and outcomes of institutional care of old people?

I examined the available literature on institutional care of elderly people at the beginning of my research, taking particular note of the contributions of different studies in relation to my own concerns: describing patients' experiences and analysing these in the context of social relations; explaining any emergent differences in both patients' experiences and associated social relations; and developing ideas about changes in the social organisation of patient care so as to bring about improvements. Some important studies have been published since my research was carried out. Discussion of these is included for, while they obviously could not have influenced my research strategy, they have been considered in the context of my own data analysis.

Classic British Studies

Townsend's major study of residential homes (1962) and life within them was based on a survey of 5% of the 3,000 residential homes for the elderly which existed in England and Wales at that time. While part of the research concerned residents' experiences, as gleaned from responses to a questionnaire, the scale of the study and its overall aims (to

describe current accommodation; the lives of people in it; to discover why people go into homes and to assess adequacy of services) did not lead Townsend to analyse residents' accounts of institutional life in the context of the social relations of residential care. In the field of hospital care, an early study was that of Norton et al (1962). Norton aimed to further the understanding of nursing care needs of elderly patients, thereby contributing to developing better standards of care. She looked at a range of problems including the physical and mental state of patients; ward routines; the nature of nursing care given to patients; ward furniture and equipment; suitable clothing; the prevention, aetiology and management of pressure sores. In nursing circles, this study is regarded as a classic. Norton's concern with nursing problems of geriatric patients, however, did not lead her to focus on ward social relations and their significance for patients' experiences.

Geriatric Nursing

Besides Norton's, studies taking nursing care as their point of departure include those of Wells (1975, 1980), Baker (1978), Clarke (1978) - a sociologist - Miller (1978), Fielding (1982), and Badger (1983). Most of these studies were carried out by nurse researchers who were troubled by what they saw as monstrous problems in geriatric hospital care, and I shall now discuss them. The hospital geriatric patient has more contact with nurses than anyone else, so I consider it essential to take careful account of what the social research of experienced and concerned nurses has to say about substantive problems, also the issues that remain unaddressed.

Wells commenced her research in 1972 and her book (1980) is very similar to her unpublished Ph.D. thesis (1975). Thus I will discuss the research as described in her book. The aim was to describe current nursing practice in order to develop a potential model for geriatric nursing, which lacked, as Wells saw it, a distinctive body of nursing knowledge and skill. Working in a single hospital, Wells' starting assumptions were three: that nurses' behaviour was influenced first by the physical work environment; second, by their attitudes towards geriatric patients; and third, by their knowledge of the cause and treatment of patients' needs. She explored each of these through different substudies involving surveys as well as observation. Wells' findings were on the whole depressing. She concluded that the environment posed many problems and, on top of that, most nurses lacked the understanding and knowledge necessary to cope with the nursing care problems of their patients, never mind to promote change. This was true of trained as well as untrained staff. However trained staff had positive attitudes towards old people, and saw the answer to all their problems as resting on the provision of more staff. Taking the failure to implement a personalised clothing scheme as an example, Wells found the nursing problems to be more complex: there was a lack of awareness about current practices, the aims of the scheme were never clarified, the scheme was not explicitly planned, communication and co-ordination were lacking and the scheme was not systematically monitored - a step which might have helped avert the scheme's demise.

Wells used observational methods to discover how geriatric nurses spent their time. Again, her findings were depressing:

"... the nursing work ... was not focussed on the patients' needs but on ward routines which might or might not be appropriate for each patient. The work routines were based on minimal, universal needs such as meals, commoding/ changing wet pads, 'getting up', and 'going to bed'. Work was not organized in the sense that it was assigned in any manner. Routines were determined by the time of day, and the work progressed in bursts of frantic activity by nurses working in pairs or a group of three to complete the routine from one end of the ward to another.

Further, not only was work not assigned or even focussed on individual patients but there was no nursing record of individual patient preferences and such information was not regularly transmitted ... individual patient preference or even necessary variation in care appeared to be obstructive to the work goal, which was the completion of the routine. Thus, the problem of nursing work in geriatric wards was not so much shortage of staff as the fact that such work was neither sensibly organized nor provided the likelihood of helpful care for patients.

Patients' physical care problems were not the central issue. Nursing staff were not concerned about any specific patient problem; their prime concern was the completion of ward routines. The nurses were satisfied with these routines" (1980:127-8)

Wells felt that nurse-patient communication was a central issue, and she then turned her attention to this, and found that nurses talked but little with patients, and in their talk they tended to be more concerned about tasks and things than about the patient's thoughts and feelings.

Despite her catalogue of gloom, Wells is able to conclude that nurses in geriatric wards work very hard and are well-meaning (p.129). She goes on to add:

".... they work very hard at and are well-meaning about the wrong things" (p.129).

She sees the problems as primarily to do with the socialisation of nurses in a ritualistic fashion into an authoritarian system. She calls for changes in nurse education with emphasis on a problem solving approach, and in particular argues that education in geriatric nursing as a

specialty has been woefully neglected.¹ Essentially, Wells believes that the path towards improvements lies with the nursing profession, and contains elements of education and re-education, research and redefinition of appropriate ways of doing nursing work in the service of patients - a long-term set of ambitions. In the short-term, Wells suggests that clinical nursing experts in geriatrics should work alongside ward sisters to teach and act as role models.

Wells' study is a very important one, not least for its systematic analysis of the problems identified. But her focus was on nursing problems, and she ends up by looking solely to the nursing profession for solutions. Indeed, her three starting assumptions all refer to nursing in implied isolation from its social and professional context. She did not look directly at the patients' perspectives, nor the wider social context in which ward geriatric nursing is done. Thus while alerting me to the nursing side of things in geriatrics at the planning stage of my research, and, by implication some of the suffering which patients might experience, I hoped to develop a different analysis both of work processes and patients' experiences.

Clarke's (1978) study was concerned with the wider influences shaping nurses' perceptions of geriatric nursing work. She interviewed 75 nurses about how they saw their work, and the satisfactions they derived from it. She felt that the level of satisfaction was influenced, among other things, by perceived alternative job opportunities. In her sample, these were seen to be factory jobs or work in shops or laundries;

¹The Joint Board of Clinical Nursing Studies introduced two courses in 1974, one of 27 weeks, the other of under 8 weeks, in Care of the Elderly and Geriatric Nursing for registered and enrolled nurses. (JBCNS, n.d.)

and work on the geriatric wards was seen as akin to factory work: a series of physical tasks to be 'got through'. Shortages of staff reinforced this view of geriatric nursing work. Clarke suggests her findings have policy implications: in working towards ameliorative changes, it is vital to take account of nurses' definitions of work and to involve nurses themselves in policy development.

The findings reported by Baker (1978) unfortunately remain largely unpublished. Like Wells and Clarke, Baker is concerned about geriatric nursing. She reflects on the curious tensions evident in the specialty: the claim by some (e.g. Norton, 1965) that geriatric nursing well done represents the very essence of professional nursing work; as contrasted with the disparaging and despairing views of geriatric nursing work as 'dirty work', to be 'got through' (Clarke, 1978). The research topic she tackled was that of the relationship between nurses' perceptions of their work as evidenced in what they said about it; and nurses' work behaviour as observed by Baker - herself an experienced nurse. Valuable though she felt Wells' study to be, Baker considered that this vital question - in relation to improving practice - had not been fully explored by Wells. She studied five geriatric and two medical wards in the same hospital, by means of participant observation. She found that geriatric patients were perceived as enjoying less than adult status, and that the prevailing style of nursing was what she called 'routine geriatric': the application of broad-based routines to whole groups of patients, irrespective of considerations of individual need or preference. She accounts for this in terms of medical priorities and expectations, first of all. Little medical attention is accorded to those patients deemed unlikely to make a speedy recovery to a point at which they can be discharged. The low

status accorded to patients who do not fit this category is mirrored in nurses' perceptions of such patients. This arises through the traditional primacy of the doctor's role and the pervasiveness of the idea that cure and discharge are to be valued above all else. The 'routine geriatric' style of nursing is reinforced by various structural factors. Wards which attract low levels of medical attention tend to have poorer levels of staff and other resources. Administrative priorities of nursing managers and some doctors - tidy wards and a quiet life for example - are best met by following the routine geriatric style. A patient-centred style might mean, perhaps, that beds remained unmade for long periods while patients' needs were attended to; or that doctors might have to wait for the completion of nursing care work with patients before beginning a ward round.

There were some exceptions to the routine geriatric style, notably two ward sisters, one of whom was successful in promulgating a patient-centred style of work among her primarily untrained nursing staff, the other of whom was not. Baker speculates about the reasons for her findings, and in a 1983 paper, she argues that both nursing management and medical routines tend to reinforce the 'routine geriatric' style. Nurse managers dislike being constantly worried about poor staffing levels, and are more concerned about the completion of required paperwork than devoting time to patients' happiness. The consultants on the ward discussed refused to see patients in untidy areas of the ward and objected to having their rounds interrupted in order that Sister could attend to a patient when no other nurse was available (Baker, 1983). Baker's findings, implying as they do a lack of humanitarian concern for patients, lead her to suggest some radical changes. She calls for a complete reorientation of the nursing profession such that nursing care is provided to individual patients as individuals. This requires that a nursing assessment is made, together with the patient, of the patient's needs, and of realistic goals for

Text cut off in original

nursing care. (Baker's work was completed before the 'nursing process' revolution really took off in the U.K., but essentially what she proposes reflects the philosophy of the nursing process). A parallel requirement is that the status of geriatric nursing be raised.

If the primacy of the 'caring' role within nursing could be more firmly established - as opposed to the almost unquestioned pre-eminence of medically-related nursing work - then the status of geriatric nursing would be dramatically improved. She also calls for the organisation of long-stay institutional care of patients whose needs are primarily for nursing care, outside the hospital system and under the clinical management of nursing, and suggests that experimental units be set up. (This is in fact now happening, Bond, 1983). Unfortunately, Baker does not develop her analysis of how new organisational and nursing models might in practice be developed. I hope to be able to make a contribution here on the basis of my own findings, which in many ways complement Baker's (see Chapter 8).

While Baker is very much concerned with the impact of nurses' perceptions of patients and their work behaviour on the patients themselves and quotes much case material bearing on this, she does not seek to offer a systematic analysis of individual patients' experiences. It is necessary for research to do just this, in order to further the endeavour of developing a better deal for patients who receive long-term institutional care.

Miller (1978), another experienced nurse, looked at the behaviour of long-stay patients in psychogeriatric wards. She was concerned with the relationship of patient care outcomes to nursing care. She observed three patients in each of six wards, in three different

hospitals. She rated their behaviour, over the waking day, for engagement/disengagement (Jenkins, et al., 1977: the basic premise is that high engagement is to be preferred). She also used a modification of the British Geriatric Society/Rcn checklist (1975) for improving geriatric care as a yardstick of the quality of care on each ward. She found that nurses on all wards were unclear about the goals of their work. She judged physical care to be adequate on all the wards, but there was wide variation as to the extent of consciousness about preserving patients' identity and dignity. On all wards, patient choice and independence were low. She observed that the patients were disengaged, i.e. doing nothing, staring into space, passively watching, for at least 50% of the time. The more demented patients had slightly higher levels of disengagement. But on average, only three hours out of a 15-hour day were spent in either manipulating objects (e.g. cutlery at mealtimes) - one of the indices of engagement - or in contact with people. Almost all nurse-patient contacts were to do with physical care task performance - 'batch-processing' of patients was the order of the day. Miller, like Baker, calls for an individualised approach to nursing, in the light of her finding that on one ward showing some evidence of attempts to individualise care, the most severely demented patients showed a higher level of engagement than comparable patients on the other wards. Miller's small-scale study suggests links between patients' behaviour and experiences, and the organisation of nursing work. The link between work organisation and patient care outcomes is implied by Baker, and demonstrated in the context of psychiatric wards by Wing and Brown (1970) and by King, Raynes and Tizard in child care institutions of different kinds (1971). Miller is not able to take the analysis of these links very far, nor does she look at the wider social context of ward work.

In a book on action research and organisational change from within (Towell and Harries, 1979) Savage et al (two nurses and a social worker) report on their researches into their own work, motivated by a concern to change work patterns so as to be able to spend more of their time - as nurses - in talking with patients. They assessed their patients' needs, and kept diaries to check how their work time was spent, and which patients the nurses had most contact with. They found that most of their time was spent in performing physical tasks, and that they spent least time with patients who were moderately dependent, physically and mentally - probably because the least dependent were more rewarding to spend time with, and the most dependent simply had to have more tasks performed on or for them. In the light of their findings, various changes were made to the ward regime, so as to build in far greater flexibility in the use of nursing time. This led on to other developments, such as shared NHS/social services responsibility for admitting psychogeriatric patients to hospital and participating in their rehabilitation and support. An important lesson from this is that participation of interested parties in devising change is very important if change is to get off the ground.

Fielding (1982), coming at problems of geriatric nursing from the standpoint of nurse and psychologist, took up the idea that nurses' socialisation is crucial in influencing their work perceptions and practices. She was interested in student nurses' attitudes towards old people, and how these attitudes were formed and changed. She studied conversational exchanges between students and patients and the students post hoc 'accounts' of these conversations as a means of exploring their purposes and attitudes. She also used a repertory grid technique to examine changes in attitudes during training. To over-simplify

somewhat, she found students' attitudes towards patients and their accounts of conversational purposes mainly centred around the problems - or lack of problems - individual patients posed for the management and execution of nursing routines: how difficult or easy the patients were to nurse and strategies for rendering the 'difficult' patients 'easier'. From the repertory grid attitudinal assessment, she found that students' views of patients' needs tended to become more concretely orientated and less psychologically orientated as their training progressed! Fielding did not look at patients' experiences per se, nor, other than indirectly, at the wider social context of geriatric nursing work, but her study is important for what it tells us of the challenges of nurse training and education and how these might be met. Other nurse researchers in this field - Norton, Wells, Baker and Clarke - all discuss the central role that 'proper' education might take in reforming aspects of practice.

^ (1963)
Badger, an experienced nurse, focussed on a very specific nursing care problem: practices of toileting and changing elderly patients in hospital. She evolved a structured method for recording her observations of 424 incidents of toileting and changing patients in four geriatric wards and one general medical ward. She found various instances of thoughtless, ignorant or 'bad' practice often incorporated into routines. As the analysis unfolds, it becomes clear that nurses' behaviour in this apparently precisely circumscribed area of work is subject to numerous influences, including relative ignorance of approaches to promoting continence and proper use of the various appliances and aids to the management of incontinence, availability of supplies, ward custom and practice, perceived staffing levels and workload, perceptions of patients (too demanding), lack of administrative understanding of nursing needs

in relation to promotion of continence (which compounded supplies problems) and the low status of geriatric nursing. Nurses were aware that in many cases, they were the only staff who were in practice interested in the patients. If nurses' behaviour in this one area of work - which by implication has important effects on patients' experiences - is subject to so many influences, then it is necessary to cast a wide net in seeking to understand the social context of ward work as it shapes patients' experiences.

Resumé: Studies of Hospital Nursing Care of Geriatric Patients by Nurse Researchers. While the studies discussed offer much which is of value in understanding the problems of geriatric nursing, only Baker offers an inspiring vision of radical change: tantalisingly, she has to stop short of developing practical ideas about strategies for moving towards her ideas for improvement. Only Miller attempts to base her analysis of geriatric nursing on patients' behaviour, but the links between patients' behaviour and experiences and the wider social context of geriatric care are scarcely considered. I will turn next to discuss the contribution of some other studies of institutional care of the elderly. None of these was initiated primarily from a concern with geriatric nursing care: a range of perspectives guided the definitions of aims, the methods adopted and the analyses which developed therefrom.

'Ethnographic' Studies

Paterson (1977) carried out a study of the social organisation of old people's homes. As a participant observer, she studied three local authority and three voluntary homes for the elderly. The staff were her primary focus, but she stressed her concern with finding out what are the reactions of elderly people to becoming the work of others;

in other words, with the perspectives of the elderly residents on their experiences. She observes that there is almost no literature on this, and that unless elderly people's own accounts of their experiences are incorporated, then research is in danger of merely reinforcing social stereotypes of old people - e.g. as somewhat less value than 'normal' adults, and as people whose problem is that of 'adjustment'. Paterson draws heavily on Goffman in her selection and analysis of data from the twenty-five quarto notebooks containing her fieldnotes. She discusses residents' strategies for maintaining their personal identity in the face of personal, social, moral, physical and mental labelling by staff through routines of care-work and organisational processes for decision-making. These last are all geared to rendering residents predictable and therefore controllable.

Much of Paterson's copious case material from the setting of the residential home finds parallels in my own research, but her research methods were not quite appropriate to my endeavour of relating the social context to the central core of study: patients' experiences. She was not, furthermore, seeking to use research findings to think about new approaches to residential care, other than to underline the mistaken assumption built in to so much research, that the 'problem' of care of elderly people is one of 'adjustment'.

Clough (1981) reports a participant-observer case study of a single residential home carried out over a twelve-month period. As an experienced social worker, he felt that understanding residential care of old people - the need for it, its processes and outcomes - involved analysing residential care in depth, in order to distinguish the myths

from the realities. The aim of his study was to explore the links between practices in an old people's home and a typology of institutions which he developed from an analysis of gerontological theories of ageing - which embody contrasting assumptions regarding attributes of 'successful' old age - combined with varying levels of resident control over their own lifestyles. The three types of gerontological theory are:

1. Activity theory, which holds that 'successful' adjustment to old age requires active participation in a wide range of social roles (see Havighurst and Albrecht, 1953).
2. Disengagement theory, which views 'successful' adjustment as a process of gradual and mutual withdrawal of the individual from society and vice versa, in anticipation of the ultimate withdrawal: death (see Cumming and Henry, 1961).
3. Socio-environmental theory, which sees contentment in old age as deriving from goodness-of-fit between an individual's expectations and experiences (see Gubrium, 1973).

Clough's typology of institutions is as follows:

Figure 2.1: Clough's Typology of Institutions

View of ageing held by institutional staff

Control of lifestyle by resident	Activity	Disengagement	Social environmental
Minimal	Nursing home	Institution	'Home'
Some	Therapeutic Unit	Hotel	Hotel
Maximal	Retirement Community	Flatlets	Supportive Unit

A critical analysis of Clough's typology could be advanced, but would serve no useful purpose here: it is his general approach which is of interest. He believes that practices within homes are related to the attitudes to ageing of the people in the home and interested parties outside. Clough's detailed analysis of life in The Pines, from residents' and staff's point of view, does not fit neatly with the initial typology which he developed. His findings lead him to reflect on the many inherent contradictions and conflicts to be found in institutions caring for old people. He concludes that such homes are in effect taking on all the ambivalence of society at large towards old age and old people, and calls for clarification of the purposes of homes and of the tasks of staff. Thus, he says, it may become

"...possible to escape from demands that can never be fulfilled and that leave everybody, residents, staff and relatives, dissatisfied. More precise statements may then be made as to what may be possible within a home" (p.204).

Clough believes this is important, as he sees residential homes as being necessary and having the potential to offer a reasonable life. There are three core principles to be upheld:

"the very old are adults with a right to choose, a right to privacy and a right to be helped" (204).

Clough's study is important for its contribution to relating processes of institutional care of old people to wider societal beliefs and attitudes. Implicit in it are many ideas for change. It was not, however, part of Clough's intention to develop these, and the scale of his study did not lend itself to this, in any case.

Fairhurst's (1981) ethnographic study was underway when I was beginning my research, and several papers on selected aspects were available. She aimed to analyse the perspectives of different professionals - particularly those involved in rehabilitation (nurses, occupational therapists, physiotherapists and medical social workers) - and geriatric patients on the process of rehabilitation. From her work in a geriatric hospital, Fairhurst shows how the different participants in rehabilitation hold varying definitions of its meaning. There are interprofessional tensions regarding the ownership of different areas of work, and a range of partially conflicting definitions of what 'successful' rehabilitation is. Patients' own perspectives do not necessarily fit with any of the staff's categories. Life in the geriatric hospital is partially about processes for controlling work and negotiating mutual accommodation within the staff group. The ethos of rehabilitation through teamwork in geriatric care creates, of itself, a strong imperative for achieving a more-or-less consensus view. Fairhurst's analysis of case conferences perhaps illustrates this most sharply: discussions were as much about justifying different

courses of action and guarding the use of precious resources, such as staff time, as they were about actual patients.

Fairhurst states that:

"A major rationale of my study is that an understanding of the process of rehabilitation can be gleaned only from weaving together two separate dimensions: that of doing rehabilitation and that of being rehabilitated" (p.321)

The richness of Fairhurst's case material amply bears this out.

Although, as Fairhurst says;

"This study was not embarked upon as an exercise to ascertain the constituents of successful rehabilitation rehabilitation criteria (have been treated) as a topic for analysis in their own right" (p.321)

she refrains from making explicit judgments about the implications of her findings for practice. Her case material illustrates many confusions, stresses and problems for all the participants in rehabilitation, as well as some happy outcomes. It is a pity that these are not discussed further in relation to possible alternative models for rehabilitative work.

These three ethnographic studies all focus on the residents'/patients' perspectives. None of them, however, develops to any very great extent reflections on implications for practice. Perhaps they would have felt it inappropriate to do so given the nature of their data base. Of great value is the careful and detailed mapping of particular social processes in care of the elderly as they affect the elderly themselves. Researchers other than ethnographers have been interested in residents'/patients' perspectives.

Miscellaneous Studies

Three totally disparate examples are studies by Meacher (1972), Raphael and Mandeville (1979) and Godlove, Richard and Rodwell (1981).

Meacher's research was motivated by concern with a social policy of the 1960s, which advocated provision of specialist residential homes to cope with the mentally confused elderly. He felt that segregation as a policy might merely lead to intensified stigmatisation of an already low-status group within the elderly population. Through observation, interviews and written records of various kinds, he studied residents' experiences in three specialist and three non-specialist homes for the elderly. Although Meacher's study is widely quoted in the literature, I do not find it an easy task to evaluate it. His account of his methods is in places confusing, for example it is never made clear exactly how residents' confusion was assessed - whether his specially designed assessment instrument (not reproduced in the book) was used by himself or staff. His argument that "'confusion' is seen less as an endogenous condition than as a system of 'logical' adjustments to a mystifying insecure and alarming environment" (p.280) may indeed have some substance, yet it is controversial and, to my mind, remains so despite Meacher's presentation of his data in support of the argument. However, an extremely valuable outcome of the study was to increase the visibility of public debates about the plight of the mentally infirm elderly and their carers.

A totally different kind of study, focussing on the consumers' view as well as that of the providers of health care, was that of Raphael and Mandeville (1979). This was an opinion survey of geriatric hospitals, seeking views on environment, equipment, staffing levels and lifestyle.

A part of the intention was to design a 'package' which any geriatric hospital could use for itself as a means of monitoring its own performance. There is clearly a place for such studies, but because of inherent problems of any opinion survey, which have been discussed elsewhere by many researchers, e.g. Cartwright (1964), they have only a very limited contribution to make when it comes to understanding the aetiology of differing patterns of expressed opinions and/or considering strategies for tackling any problems which may come to light.

Godlove, Richard and Rodwell (1981) are concerned about change. The broader study, of which this report (1981) forms a part, concerned the policy question of investment in different forms of care for old people. British and American data were collected about care provided in different settings, characteristics of those being cared for and outcome of that care. That part of the research reported in 1981 relates only to describing:

"what happens to elderly people when they receive care or services ... by directly observing ... to describe the everyday experience of individuals ..." (p.2)

Godlove et al note that there are few reports about delivery of services to old people based on observation and that those few are concerned more with the problems of the providers than the recipients, e.g. Norton et al, Wells. They note some exceptions - Meacher, the engagement studies of Jenkins et al (1977), Davies and Snaith (1980) - but these don't focus on individual patients. Godlove et al describe their carefully-designed strategy for recording continuous observations of the events of the daily lives of individuals in four care settings: day centres, day hospitals, residential homes

and hospital wards. Several examples of each were included. They also assessed, using standard measures, patients' dependency levels and whether or not they were demented. This study was not published at the time I began my research but, while their methodology might have partially met my requirements, it would have proved impossible for a lone researcher to adopt their strategy. Further, they did not set out to collect data about the quality and nature of the events they observed, nor about the wider social context. The most striking finding was that the greatest proportion of old people's time was spent in isolated inactivity. This perhaps comes as no great surprise. Comparing the four research settings, day centres came out better than day hospitals, which in turn were better than residential homes. Hospital wards' data showed the highest proportion of patients' time spent in inactivity.

Although the study was strongly quantitative, the observers could not help themselves in making notes about incidents which particularly struck them. They cite some examples of excellence, but note that there is a tendency to record the appalling and perhaps to take good practice for granted. A majority of their examples come from hospital wards, and they say that they did not single these out for particular criticism but that it was simply the case that more instances of shocking circumstances struck them in this setting than in any of the others. A point worth stressing is that these researchers had not set out to collect data on the quality of patients' experiences, and were not in a position to offer a systematic analysis.¹

¹My own findings derive from analysis of inhumane treatment. That a preponderance of 'negative' incidents moved Godlove et al sufficiently to note what they observed, provides another source of support for the legitimacy of my use of analysis based on negative observations, yet detached from a moralistic or emotive stance, and applied in a rigorous fashion.

Godlove et al's study is also of interest in that they consider - in very general terms - possible strategies for improving the depressing situation they found in the residential, and particularly the hospital setting. They collected data about staffing levels which, though not fully reported, leads them to conclude that increases would not directly result in 'reducing patients' deprivation of opportunities for social contact and enjoyable activities. (This is in line with my own findings set out in Chapters 4, 5 and 6). Instead they suggest a complete reorganisation of the work process is needed, essentially away from the all-pervasive routines of housekeeping and personal care, and towards providing for a range of interesting and creative activities and events and, above all, putting the patient at the centre of the enterprise. Although this has been advocated for many years past, little change seems to have taken place since for example Barton's (1959) study of 'institutional neurosis' and his recommendations for tackling it. A contributory factor is that staff working in settings where bad practice is commonplace quickly socialise new staff into existing practices and, with almost no educational input as a counter-balance, the reproduction of low standards is assured. Godlove et al found that senior staff from various disciplines showed little active concern about standards, As such, it is scarcely surprising that care workers did not seem to be actively concerned either. From their own experience of research in care settings, Godlove et al write with feeling about the difficulty of sustaining any normal social conversation or contact with patients in the absence of anything to talk about. Their main recommendation to initiate the much-needed changes in these environments is to restructure work so that the nursing staff are enabled to organise

a wide range of activities and events which become an integral part of the care setting and which offer patients the chance of a less deprived experience of care.

Three major studies have been reported recently, all of which are centrally concerned with practical, low-cost strategies for tackling problems of long-term and/or institutional care of elderly people. All three were commissioned by DHSS, and I will now consider them.

'Managerially-inspired' Studies

Studies of this type are, these days, very important, not least because in an economic and political climate which does not favour social research, government-commissioned research is the most likely to survive. None of the three studies which I shall refer to here was reported on until my own research was underway. Nevertheless, I will discuss them because they are all key studies in the British scene, representing the current state-of-the-art of research into institutional care of the elderly as well as reflecting government concerns. It is pleasing to note that all three studies incorporate attention to residents' perspectives, two of them through interviews, the third through interviews and observation.

Evans et al (1981) report on a study which aimed to describe characteristics of residents, physical and social environments, staffing, management practices and attitudes of residents and staff in residential homes having populations which varied with respect to levels of physical and mental disability. The outcome of the study was recommendations

about the desirability and practicability of managing mentally impaired residents in non-specialist homes, ways to improve the physical and social environment, ways to improve physical care, organisation and management and the changes in staff levels and training which all this might imply. Six homes were studied by a team of researchers. Research methods were structured, and the sophisticated research design included use of a checklist to describe the physical environment and assess staff opinions about suitability; use of staff members as informants on residents' social, demographic and behavioural characteristics; interviews with staff about their background, training and attitudes to residents, work and its management; structured observation of staff performance of physical care tasks of bathing, dressing and toileting; structured observation of levels of social interaction and residents' 'engagement' (Jenkins et al, 1977); a checklist to rate managerial practices and finally, interviews with residents covering their attitudes to life in residential care. In the discussion of their complicated findings- the researchers are careful to point out that decisions about desirability of mixing residents of varying levels of physical and mental disability ultimately rest on value judgments. Also that regardless of what the (value-laden) policy might be, given the demographic characteristics of the elderly population and existing levels of residential resources, it is inevitable that there will be mixed-disability populations in non-specialist homes. Although many of their findings do not depart from the well-established trend of relative gloom and despondency, Evans et al are able to say that:

"at least minimum standards and usually much more can be achieved where there is a mix of confused and lucid, and physically disabled and able residents" (p.9:11).

They say that attention should also be paid to the social-class, age and sex mix of residential populations, but in their further discussions, Evans et al say that having studied homes containing between 10 and 50% confused residents (as defined by Crichton Royal Behavioural Rating Scale) and reviewed other available research, around 30% seems a workable proportion. Their discussion of the population mix is carefully qualified in the context of considerations about quality of life, staffing practices and levels, and staff training. They begin to analyse strategies for improving the situation, and call for greater attention to be paid to residents' individual needs including need for self-determination, in both physical designs and social organisation of residential establishments.

It is a pity this study was not available at the start of my research. But even if it had been, it did not directly address all my own research interests and problems. Evans et al were a research team, and chose to use a structured approach in researching a managerially-defined problem in relation to resident populations whose behavioural and social characteristics had to be assessed by staff informants - an approach which engenders much criticism (e.g. Booth, 1983). They were perhaps unable to develop their analysis of future policy and organisational options very far, e.g. to consider radically different alternative approaches to residential care, given that their study was an officially commissioned one. Although from this and other studies of residential and hospital care (as discussed above) there seem to be a lot of common features of both environments, the organisational settings and mode of entry to the two types of facilities are crucially different, as are their ostensible aims. Thus any research-based analysis of fresh approaches to residential care is bound to be limited when it comes to thinking about the parallel problems of a hospital setting. The two

need to be analysed separately. But their many shared problems and the overlaps in their populations (demonstrated time and again, e.g. Dodd et al 1980) mean that in the end, administrative and professional divisions must themselves be subject to review by means of a research-based focus which begins from the needs of the dependent elderly themselves rather than from the needs of the array of services which we currently have.

Another commissioned study, which takes as its point of departure current service boundaries and the overlap between the populations served by the different sectors, is that of Wade et al (1982, 1983). Wade (1983) says that the research was initiated to investigate factors relevant to consideration, by policymakers, of the introduction of nursing homes in the NHS, as a new form of care provision for the frail elderly. This possibility presented itself in the light of increasing pressures on existing forms of care. Even before the research was completed, the DHSS had already embarked on setting up three experimental nursing homes, and a five-year evaluation research project was commissioned very soon after Wade's final report was presented. Thus the research findings themselves may have had only marginal influence on policy decisions. However, this study is very interesting, because it is concerned with different models of care, and with matching the needs of dependent elderly people with 'appropriate' care provision. The study comprised two stages. The first aimed to assess the needs of samples of elderly people in different 'sectors of care' for nursing care and hospital-based resources. Six care sectors were identified: domiciliary, local authority residential homes, voluntary residential homes, private residential homes, hospital (long-term care) and private nursing homes. An instrument developed by

Wade, Elderly Person Dependency Form, was used to assess dependency. This had to be completed by an experienced informant, e.g. person in charge of nursing home. The main finding from this part of the study was that there was considerable overlap among the populations of elderly people in terms of dependency between the different care sectors: this is in accord with findings from other studies, c.f. Dodd et al (1980) noted above.

In the second stage of the study, Wade et al (1983) sought data about the factors which led old people into institutions, and about the social, physical and emotional environment of people in different kinds of institutions. A sub-sample of people from each of the care sectors was chosen - the more heavily dependent people - and interviews carried out with them (where possible) and their relatives or carers. As might be expected, the findings about factors precipitating admission to institutional care were very complicated. It will not serve my present purposes to go into them here, other than to note that there emerged no simple relationship between levels of dependency and support needed, and the provision of institutional care. So far as environments went, Wade et al found hospital wards were the most institutional in a physical sense. So far as organisation went, including the level of patient/resident choice, - based on information from staff - there were no dramatic differences between the care sectors. In homes, residents had very limited access to therapy professionals, considering their high levels of dependency. Based on their interviews with staff about attitudes towards their work with patients/residents, Wade et al identified two key continua which underly four different models of care, as follows:

Figure 2.2: Wade's Model of Care (Wade et al 1983)

Person centred	
<u>Supportive model</u>	<u>Protective model</u>
<ul style="list-style-type: none"> - consultation - patient/resident committees - choice - salience - involvement of visitors/volunteers - outings/activities initiated by the elderly - therapeutic input - unrestricted visiting 	<ul style="list-style-type: none"> - consultation - limited choice - little or no involvement of visitors/volunteers - no outings - provision of diversional activities - therapeutic input - restricted visiting
Open	Closed
<u>Controlled model</u>	<u>Restrained model</u>
<ul style="list-style-type: none"> - emphasis on routine - lack of choice - activities/outings organised by staff/volunteers - unrestricted visiting - limited therapeutic input 	<ul style="list-style-type: none"> - emphasis on routine - lack of choice - non-involvement of relatives/visitors in the care regime - no outings - restricted visiting - limited therapeutic input
Task centred	

Only the supportive model has the potential to offer 'good' care, it is implied; but this is relatively rare in practice. Because their remit was to gather information relevant to a policy decision about the possible introduction of NHS nursing homes, Wade et al did not go into the matter of how to secure the supportive model in any great detail. They stress the need for the person in charge to be both trained and experienced in providing person-centred rather than task-centred care. This they see as central. Because of the well-documented overlap among the populations

of different institutional care settings, and because the needs of old people do not remain static over time, they argue for a reconsideration of the whole array of care provision for dependent elderly people, so as to create greater flexibility and sensitivity to the needs of the recipients of care. Re-thinking institutional and service boundary arrangements, so as to preclude the need to move old people from one locus of care to another as their circumstances change is what is required. Appropriate care should be brought to the elderly rather than vice versa, a system which manifestly fails where resources are managed by separate services. They call for a joint NHS/social services nursing care enterprise. We might in addition suggest some formalised link with sheltered housing. Wade et al's arguments make sound sense in the context of their own and other research findings; as well as in terms of humanitarian considerations. But they do not tell us - and indeed did not set out to do so - how to assure in practice a greater prevalence of a 'supportive' model of care, nor do they offer us any tools for assessing the impact of changed models of care on patients' experiences.

In reviewing Wade et al's book, Booth (1983) criticises them for their service orientation and calls for a person-centred rather than service-centred type of research. While I would endorse this view wholeheartedly, I think Booth may have taken too little account of the fact that the study was sponsored by the DHSS, with a particular policy initiative in view of the time: the creation of NHS nursing homes. Viewed in that light, Wade et al's study does a formidably good job of meeting its obligations as commissioned, while recognising that a service-based approach to analysing needs of elderly people is inappropriate. Indeed, it is interesting that the summary of recommendations in Wade's

1982 report has been omitted from the 1983 book. Their 1982 recommendations can in no sense be interpreted as supportive of the NHS nursing homes experiment. The first four recommendations concern legislative changes: regarding service boundaries, registration of private and voluntary homes, the anomalous system of payment for long-term care in local authority but not NHS facilities, and provision of proper financial recompense for lay carers. The specific recommendation regarding nursing homes is that suitable existing residential homes be extended and adapted and run within:

"..... a single system which would provide both residential and nursing home care and which would minimise the need for relocation of elderly people" (Wade et al 1982, p.315)

a recommendation which itself implies a legislative change.

I have looked at this study at some length because it was seriously concerned with evolving different models of care for elderly people, and identifies some of the huge obstacles which would need to be taken on in attempting to change the system, whether within a single care sector or across the boundaries. Perhaps it is always difficult to develop radical analyses of new care models out of a government-commissioned research study.

The last study I will summarise here is that of Willcocks, Peace and Kellaheer, and concerns residential homes. It too is a commissioned study, differing considerably from both Evans et al and Wade et al. Willcocks et al (1982) summarise aspects of the research - which has been written up in various weighty reports - and it is this summary which I shall draw on.

The research was commissioned by DHSS to provide data for a revision of the Local Authority Building Note (DHSS 1973) about design

of old people's homes. DHSS wished to encourage architects to create innovative designs, and the research was to provide information which would feed into this process. The project involved interviewing at 100 old people's homes,

"... to identify the environment and accommodation requirements from the perspective of the elderly residents" (p.240)

One-thousand residents and 400 staff were interviewed. Willcocks et al are, above all, concerned with ways of enhancing quality of life of both residents and staff. They found that residents' control over their physical environment was virtually non-existent, and in their recommendations, they sought to address this problem in the light of their interview data. This showed that residents:

"aspire towards self-determination ... demand a single room; ... want to control their own physical environment ... do not look for increased participation in communal activities" (p.248).

In paying attention to individual needs, Willcocks et al suggest that a 'residential flatlet' might prove very promising. This would be something more than a single room, offering space for personal possessions, private sanitary arrangements, and facilities for preparing snacks and drinks, and of course personal space. A communal dining room and separate lounge would offer venues for social interaction, and help avoid isolation, particularly for the very frail. A residential home built around residential flatlets might, Willcocks suggests, create strong imperatives for more individualised care of residents as opposed to 'batch processing', which would offer benefits for residents and staff.

The comprehensiveness of this survey is impressive, and the consumers' view is taken as central. For my own research purposes, it is as well to be reminded that physical environments have a bearing on the

social interactions going on in them. This study has also happened upon new findings: e.g. Willcocks (1982) uses demographic data about resident populations to show that the experience of being admitted and of adjusting to residential life may be quite different for men and women. I too happened upon gender as an important feature in the social relations of patient care, and I will discuss my findings in Chapter 7.

All three of these commissioned studies are, in one way or another, interested in models of care. Several of the studies I have discussed in this chapter make reference to a study from another field, that of Miller and Gwynne (1972) who analysed residential care of physically handicapped people. I too found this study very valuable in my analysis, as it goes further, perhaps, than any of the studies of institutional care of the elderly in making explicit the deep-seated conflicts of interest and priority between staff and inmates, which (without necessarily taking up any particular psychodynamic model) must be addressed in any serious attempt to develop models for institutional change. I will now summarise its main points.

A Life Apart

In looking at residential homes for the physically handicapped, Miller and Gwynne reflect on the aims of their study in the context of the huge literature documenting institutionalisation. They hoped to move beyond diagnosing problems towards proposing appropriate changes which might bring about better models of residential care for incurables. They note that all types of institution generate horror stories from time to time, but that analysis of instances of

deliberate sadism (which they say is rare) was not their main intention. Rather,

"The presenting problem ...was... the well-intentioned managements and staff whose behaviour nevertheless appeared to compound the negative effects of institutionalisation rather than alleviate them. Very infrequently one heard of the reverse; how and why this happened was obscure" (p.21).

Thus their study involved two stages: first, identifying more clearly what was involved in providing residential care for incurables; second, through action research, discovering ways in which appropriate changes could be brought about.

Their in-depth study of a small number of institutions was guided by the concepts of open systems theory as developed through the Tavistock Institute. A key notion is that of primary task, with which are associated input processes, conversion processes and output processes. They argue that having an input of incurably crippled people who are by definition debarred from a range of 'normal' social roles, and have been 'rejected' by society, the institution's primary task

"is to care for people who are socially dead for the time-span between social death and physical death". (p.82)

Miller and Gwynne identify two major sets of values in relation to the socially dead: first, what they call 'the humanitarian defence'. This involves preoccupation with prolonging physical life, and avoidance of any questions about the quality of lives thus preserved. The 'liberal defence' features denial that the inmate is abnormal; thus hopes of both physical and social rehabilitation are fostered. It is from these two sets of values that Miller and Gwynne's two major models of institutional care spring. The warehousing model has as its primary task the prolongation of physical life, and is

essentially a hospital model. The intake is a patient suffering physical malfunction. The conversion process is the application of medical and nursing care to an essentially dependent and passive patient who accepts the institutional definition of his other problems and of 'appropriate' strategies of care. Indeed, any attempts at self-determination by inmates are positively obstructive to the efficient attainment of institutional goals. Since 'cure' is not possible, and the only outputs are dead patients, the cure task of the hospital model is transposed into the task of postponing death. The warehousing model is the traditional approach to residential care.

In contrast, the horticultural model, associated with 'liberal' values, treats the need for physical care more as a constraint than a primary task. Inmates are seen as people who are prevented from full exploitation of their own capacities. Thus the main task is to develop these capacities. The conversion process features encouragement of individuals' greater independence. Thus staff are mainly concerned with providing opportunities for self-development of inmates rather than with treating the physical disability itself. Miller and Gwynne say that the horticultural model represents more of an aspiration than a reality. As with the warehousing model, it suffers great inadequacies: the emphasis on maintenance or improvement in independence may be inappropriate or even cruel for some people. Indeed, Miller and Gwynne say that neither model can be adequate because both are essentially social defence mechanisms developed in response to the institution's task: processing people committed to it, and thus defined as socially dead, until the time of their physical death.

Put another way, the task is to help people make the transition from social to physical death: this involves recognising people's rights to decide how to spend the intervening period, and helping to provide the facilities for individuals to implement their decisions about how to spend their remaining lifespan. Both the warehousing and horticultural models fail to recognise the right to individuality and choice. Their very failure in this respect constitutes the core of their defences against explicit acknowledgement of the consequences of recognising inmates' rights to decide on how to manage their own social death, which, taken to its extreme, might include the decision to end physical life. Miller and Gwynne's challenging definition of the institution's task is that:

"without either destroying the inmate's individuality or denying his dependence, (it is the task of the institution) to provide a setting in which he can find his own best way of relating to the external world and to himself" (p.90)

Their analysis of what they found in five institutions lead Miller and Gwynne to propose that three distinct organisational subsystems are needed if there is to be any hope that institutions for the physically handicapped can carry out the primary task as just defined. The 'caring' system caters for meeting inmates' physical and material needs, the 'independence' system provides the opportunities for inmates to develop their own capacities should they so wish and the 'support' system should embody the capability for recognising and responding to the psychological stresses of both inmates and staff. The crucial influence of the head of the institution on its culture, custom and practice is noted, and Miller and Gwynne observe that where the head has no control over institutional boundaries - deciding admissions, for example - there tends to be emphasis on the physical care aspect of work, together with dependency of inmates.

Perhaps uncertainty about institutional boundaries is compensated for by strict control internally. Other factors, too, seem to be associated with differing leadership practices. Heads who might come closest to achieving a balance among three subsystems should have effective control over external environment, have strong outside interests, be mature people and have sources of support on which they themselves can draw, e.g. an effective management committee. In considering the possibilities for change, Miller and Gwynne discuss appropriate types of staff, their experience and training - e.g. - they suggest a social work background may be better than a nursing one and that training in group work could be invaluable.

How much of this analysis might be applicable to long-term geriatric care? And how useful is it? The ideas Miller and Gwynne advance from their study are at a high level of abstraction, more akin to a set of principles for organising institutional life than to a more concrete, practical model and guide for providing care. As many writers before and since, Miller and Gwynne muse on the difficulties of assessing changes in quality of life which might accrue from any practical attempts to implement their principles. Inmate 'happiness' alone would be insufficient as a guide, institutional 'aliveness' would be better, but means of capturing this remain elusive. Miller and Gwynne present a challenging view of paths to a better future which would, in my opinion, be generally applicable to the problem of geriatric care. They also adopted an inmate-centred (but not exclusively so) stance in the conduct of their research, and the analysis that flows from it. But the implications in practice of the abstract principles proposed require considerable development and elaboration if their worth is to be tested out.

Studies of Institutional Care of the Elderly: Conclusions

In looking at the growing British body of research into institutional care of the elderly as exemplified by the preceding studies, the prevailing view derived from empirical research is rather a gloomy one, whether it be of hospital or of residential home. On p.11 I noted the similarities of opinions expressed by two concerned doctors regarding long-term hospital care of the elderly, one writing in 1949, the other in 1983. Given the 'rivers of ink' which have flowed, and the volumes of research which have been written in the interim, what fresh contribution could research make to an understanding of the problem which might offer paths towards ameliorative change? None of the researches discussed above has sought to combine all of the following elements:

1. A prime concern with patients' experiences;
2. An analysis of the social construction of these experiences which incorporates attention to the possible influence of other participants in the institutional setting;
3. An attempt to develop a simple and simplistic way of making qualitative comparisons between the experiences of individual patients within and between institutional settings which incorporates explicit attention to:
 - 3.1 patients' feelings insofar as they can be judged;
 - 3.2 collective professional beliefs about standards and
 - 3.3 normative lay views about humane treatment or, 'do as you would be done by'.

I wished to combine all these elements in my research. Before describing my research assumptions and methods in the next chapter, the final section of this chapter will turn to questions about judging standards.

Judging Standards of Patient Care

There is an immense body of literature, mainly from within nursing, on this topic. North America has been particularly prolific in this field from the late 1950s. I turned to this literature as a source of help in deciding how I would assess patients' experiences. Openshaw, a nurse-psychologist, working in the U.K., has recently reviewed work on outcome measures which purport to appraise nursing standards. (Openshaw, forthcoming and personal communication). She considers the higher level of activity in quality-related research in North America is partially because of their system of accreditation. In the U.K., the Royal College of Nursing launched a series of studies in the late 1960s, each of which looked at particular aspects of nursing care with a view to developing indices of quality. Inman (1975) wrote the final volume in the quality of nursing care series. She noted the valuable contribution the various studies had made, but considered that measures of quality might never be successfully developed because of the difficulties in defining 'ideal' care. In Britain, following the Rcn venture, nursing research turned to other topics. Only a few isolated workers continued in the field, e.g. Rhys-Hearn (1971) Rhys-Hearn & Howard (1979). This was the period immediately following the 1974 NHS reorganisation, and nurse researchers had other fish to fry. However, by the end of the 1970s and particularly into the early 1980s, NHS cuts helped stimulate a resurgence of interest. Openshaw suggests that renewed research into the quality question was seen by professional leaders to hold promise as a way of producing data which would help the nursing case in arguing for their share of ever-scarcer NHS resources. However, the fundamental problem of all measures of patient care remains, not surprisingly, unresolved: how to define 'ideal' patient care in terms

of which actual care and its outcomes can be assessed. Thus a major drawback of most measures is that they embody assumptions, which are perhaps untestable, about the outcomes of particular nursing practices for patients. They often require the user to make on-the-spot assumptions about what counts as 'ideal', and to make subjective comparisons between the data they are collecting and the assumed 'ideal'.

Despite these drawbacks, what evidence is there that 'measures' of care standards are of any use in leading to actual improvements for patients? The answer is, very little. One North American measure which has recently found favour in this country is the QUALPACS scale (Wandelt et al, 1974). Its utility is currently being researched (Smith, personal communication) and it has been used to stimulate improved geriatric care at Burford Hospital in Oxfordshire (Wainwright and Burnip, 1983). The scale consists of 68 items relating to six areas of nursing care including psychosocial care. Selected patients are observed by trained nurse observers. An overall quality score is worked out for each patient. This exercise was carried out at Burford, and the results fed back to the hospital. Just over a year later, the exercise was repeated, and the results showed that things had improved. Wainwright and Burnip point out all the difficulties about assuming what would count as 'ideal' care; about a 'before' and 'after' exercise looking at a different patient population and different nursing staff, not to mention changes in the management. Their view seems to be that what the actual scores on the scale reflect is quite unclear. The main value of the exercise lies in providing food for thought and action on the part of the practising nurses and other health professionals, and their managers. Burford Hospital is an example of somewhere which has apparently improved its geriatric care. Was this because of the

application of the QUALPACS scale? The answer to that is no. Burford is in fact unique. One of the nurse managers (Punton, personal communication) recounted how this small cottage hospital had been threatened with closure. The nursing sorority had persuaded the Regional Health Authority to designate the hospital as a Regional centre for development of and education in innovative approaches to nursing care. The new leaders appointed for this purpose seem exceptional people, and there is no reason to suppose that improvements would not have come about anyway, without the use of QUALPACS.

There is little concrete evidence, then, that so-called measures of patient care standards are much good or much use. I concluded they would be of little help to me in carrying out my research or in evolving new approaches towards providing better patient care. Before discussing how I got round this problem, I must refer to the outcomes of the British Geriatric Society and Royal College of Nursing Working Party Report, Improving Geriatric Care in Hospital (1975). This was instigated by the DHSS, and it produced a checklist for improving standards. This checklist was taken up by the DHSS, which asked eight Health Districts to review the quality of their geriatric care, as a preliminary to widespread adoption of the Checklist as a means of improving standards. Cruise et al (1978) wrote about their experience at Exeter. Essentially, their article seems to suggest that the Checklist itself offered little practical help. Many items were too vague, much was felt to be omitted and, interestingly, there was much disagreement among staff about the checklist. Some felt that particular items were so obvious and universally practised as to be not worth mentioning, while others believed the very same items to be impossible to achieve! But the Exeter pioneers reported positive developments. As in the case of Burford, these developments seemed to accrue not through the use of an externally-developed instrument, but through rather

inspired multi-disciplinary leadership which facilitated local improvements in practice. The DHSS proposal for widespread adoption of the Checklist as a means of improving standards seems to have sunk without trace.

In the light of the above considerations, I decided that I must take a fresh approach in tackling the problem of assessing patients' experiences. I thus decided to exploit the fact that it is usually easier to reach a consensus definition of concrete instances of bad or unacceptable care than of 'ideal' care, as noted by Roth & Eddy, 1967 and Godlove et al, 1981. Clearly as a social researcher investigating the social relations associated with geriatric patients' experiences, I was not in a position to develop indices - positive or negative - of the way medical, nursing or other professional procedures were carried out. However, excluding these technical procedures, I found a source of ideas - relatively unexploited by both researchers and practitioners - in the reports of inquiries into unacceptable practices in NHS hospitals and in the reports of the Hospital Advisory Service (to become Health Advisory Service in 1976). This was set up in 1969 partly as a reaction to the distressing circumstances considered in the early public inquiries.¹

Institutional Atrocities and Public Inquiries

From the 1960s, various alleged atrocities and unacceptable practices in NHS hospitals for the mentally ill, mentally handicapped and the elderly gained widespread public and political attention. This section of the literature review will consider some of the issues raised by the ensuing public inquiries. These are relevant to the problem of how research can contribute to developing new ways of analysing institutional processes and outcomes in such a way as to make

¹ Martin (1984) offers a scholarly analysis of hospital atrocities, but it was published too late for inclusion in this literature review.

more positive contributions to understanding institutional problems and the means of bringing about ameliorative changes. Examples of inquiry reports include 'Findings and recommendations following inquiries into allegations concerning the care of elderly patients in certain hospitals' (NHS 1968), Inquiries into Ely Hospital (1969), Farleigh Hospital (1971), Whittingham Hospital (1972), South Ockendon Hospital (1974) and Normansfield Hospital (1978), as well as a Review of Rampton Hospital (1980).

The first publication mentioned above deals with elderly patients. It was initiated as a result of public concern aroused by the book 'Sans Everything', (Robb, 1967), which documented appalling conditions and inhumane treatment of elderly patients in various psychiatric and geriatric hospitals. The Committee of Inquiry not only looked into the substance of the allegations - most of which referred to incidents reported to have occurred two years or more prior to the book's publication - but also reported on the current conditions and circumstances at each of the hospitals concerned. There were incidents of alleged cruelty by particular staff members to particular patients, as well as more general denouncement of inhumane practices routinely applied to large numbers of patients - e.g. bathing patients en masse, maintaining conditions of gross overcrowding on wards.

In common with circumstances leading to some of the other public inquiries, the troubles came to light because outsiders or newcomers spoke out. Although doubtless the situation was deplored by many staff, it had come to be accepted by them through the existence of shared sense of the impossibility of change, and the necessity for self-preservation under virtually intolerable circumstances. Barbara Robb was one such outsider, a visitor to one of the hospitals.

As a concerned crusader, she and a number of like-minded others used the media to invite persons with knowledge of unacceptable conditions in hospitals for elderly patients to contact them. 'Nurse Craythorne' of Bodmin Hospital was one such; she had worked for a few months as a nursing auxiliary - having had no previous experience of such work - at the hospital, and was giving an account of what she had observed after her departure from the hospital. Thus she was a 'deviant' in terms of the prevailing culture at the hospital. This was true of other informants whose accounts led to other Inquiries. Normansfield was an exception: collective action on the part of trade union members brought to a head broad ranging and long standing issues of unacceptable treatment and organisation. These had been repeatedly raised with the Health Authorities by various individuals and groups, many of whom occupied 'outsider' or relatively marginal 'insider' roles, e.g. members of the League of Friends and the Community Health Council, the dental hygienist and the education authority schoolteacher. Research studies such as Menzies (1960) have shown how ordinary people can develop individual and collective defence mechanisms to help them cope with personal stress occasioned by hospital care of patients, which, in a less extreme form from that exemplified in Inquiry reports, can result directly in causing suffering to patients.

From the 1968 Report on elderly patients, it is evident that there were several coexistent yet incompatible accounts of what 'really' went on. First, the emotionally-charged allegations of inhumane treatment on the part of the deviant hospital participants

and exparticipants. Second, the arguments challenging these which were put forward by - presumably - non-deviant participants: lack of evidence, lack of opportunity for humane treatment as a result of what were construed as massive and insurmountable constraints (like grossly overcrowded and understaffed wards), lack of credibility of witnesses: For example 'Nurse Craythorne' was said to be no judge of standards (in so many words) because she lacked nursing experience, training and knowledge and was in any case incapable of fulfilling her duties (according to the Committee of Inquiry, she was a person of 'somewhat simple mind', para. 15, p. 78). The third type of account of what 'really' went on was that to emerge from the Inquiry, which is itself full of contradictions. The problems are, of course, clearly recognised by Inquiry members:

" Anyone approaching an investigation into allegations of misconduct or negligence by nurses towards senile patients must realise that geriatric nursing demands of the nurse the highest qualities of dedication and an inexhaustible patience in the face of constant irritations due to irrational behaviour by those who are mentally confused and feeble. It would not be surprising to find that there have been occasions when, for a moment at least, exasperation overcame the self-control of the most devoted nurse; ... (but if there is evidence of maltreatment it will be clearly stated). The investigators are also faced with the difficulty of having to assess the genuineness of complaints made by elderly patients who are often confused and suffer from delusions" (Para.17, p.15).

Many of the specific allegations were concluded to be not proven, yet at several of the hospitals, the Inquiry Committee made swinging criticisms of circumstances then current. The accounts of these - inadequate, overcrowded, understaffed and ill-equipped buildings, for instance - underscore the implicit conflicts faced by staff, and the implied general suffering which patients probably experienced. The roots of persisting problems are variously identified: from

communications problems arising between senile patients and non-English-speaking untrained nursing auxiliaries, to societal attitudes which condone the 'dumping' of senile old people in institutions.

This, and the other reports referred to earlier, through their detailed analyses of the conflicting truths of inhumane institutional care, provide very important pointers towards processes of change and amelioration - particularly perhaps the Normansfield Inquiry (1978). The research community has on the whole noted these, but in general the substance and implications for theoretical and practical analysis has not really been taken up and incorporated into current research projects looking at institutional care.

The Hospital Advisory Service (from 1976, Health Advisory Service), (HAS), was set up in 1969 as a direct result of the Ely inquiry. Its aims were to promote good practices, and advise the Secretary of State on prevailing conditions. Its annual reports (e.g. NHS, 1977) contain useful analyses and recommendations for improving practice. Unrestricted publication of annual reports ceased after 1977, but is now currently being considered again (DHSS, 1983).

A possible reason why researchers have not chosen to take up the theoretical, methodological and practical lessons from Inquiry reports and Health Advisory Service, lies in the very contradictions which the Inquiries in part seek to untangle: the emotionally-laden 'truths' of the situation as witnessed by individuals or groups having different and perhaps conflicting interests and perspectives. The research climate of the sixties and even, in some schools of thought, the seventies and eighties, abhors the idea of value-laden social research. As value-

laden and political secondary sources, reports of inquiries into alleged maltreatment or other problems of hospitals have perhaps been regarded as non-legitimate material for researchers concerned with the functioning of 'normal' institutions, and not with institutions of ill repute within a given category of institution (e.g. all prisons may be of ill repute, but some iller than others).

While the atrocities may be exceptional, it is unlikely that these particular institutions are wholly exceptional as compared with others of the same category, as indeed the contents of HAS reports suggests. Also it seems easier to identify what we mean by unacceptable standards than to identify acceptable or optimal standards. Thus it seems that there may be an underexploited stance towards the research problem of furthering our understanding of the processes of institutional care as part of the impetus towards improvement: namely, a stance which seeks to produce an unemotional, systematic analysis of institutional inhumanity. The chances of achieving this are likely to be improved if the institutions under study are seen as unexceptional by the parties involved with them, neither exceptionally 'good' nor 'bad'. This kind of approach seems timely, given the relatively imperceptible improvements in practice which seem to have accrued from institutional research geared to the far more elusive notion of standards of excellence. Indeed, by scrutinising the unacceptable and establishing a systematic framework in which to do so, we may become clearer about identifying positive indices of high standards of care. This approach has the potential to bridge the gap between research studies of institutions and politically- administratively- and professionally-initiated reviews or inquiries. This gap must be bridged by social research which seeks, inter alia, practical solutions to problems.

But how relevant is the analysis of inhumane treatment in 'ordinary' institutions in general, and in institutions specialising in care of elderly people in particular? Available research suggests that it is, sadly, highly relevant, as the preceding literature review has I think shown.

Conclusion

A moving and often distressing account of being a patient is given by Ellen Newton (1980), who kept a diary recording life in a number of different nursing homes. For me, Ellen Newton's book states the case for a patient-centred perspective more clearly than any of the research literature. Recent British studies are beginning to incorporate the patients' or residents' perspectives. But there remains lacking a patient-centred, comparative study of the social relations of geriatric care, featuring a simple yet systematic means of comparing different wards and seeking to develop practical ideas for change. In the next chapter I will describe the methods by which I attempted to bridge this gap.

CHAPTER THREE

RESEARCH METHODS

Description and Assessment of Patients' Experiences

The research was not intended to pioneer a new approach to assessment of quality of patient care per se, but, in considering how to define and describe patients' experiences and feelings, I had to adopt an explicit stance towards the plethora of ideas and strategies to be found in the literature. A common thread linking much of the literature on this issue lies in the apparent lack of consensus regarding what high quality patient care consists of. Thus I decided early on in the research that it would be more practicable to use concrete indices of poor or bad care as a basis for comparing patients' experiences in and between different wards. I hoped that through focussing on bad care, it might be analytically possible to move towards some definitions of diametrically opposite indices: that is, indices of good care. Besides identifying incidents of bad care, I wished to assess the consequent suffering occasioned to patients. In order to do this, it was necessary to distinguish between unavoidable suffering - linked with the patient's illness - and unintended suffering: that which was a direct result of being in hospital, and which could not be regarded as in any sense associated with a means towards a therapeutic end. There are some obvious problems here, for example how to interpret a high rate of minor physical accidents to patients. Any accident to a patient could be interpreted as the outcome of oversight or negligence on the part of staff. On the other hand, the means of preventing accidents might be the use of physical restraint of patients. Similarly with pressure sores: under some circumstances their development could be seen as an indictment of nursing care; under others, an unavoidable feature of a general serious deterioration in a patient's condition as she

moves towards death. The pilot study revealed these kinds of complexities, thus analysis of ward-wide quantitative data on accident rates, pressure sores and routine use of analgesics and sedatives which had originally seemed promising as indices, were not pursued in the main study. I decided that description of patients' experiences, in all their complexity, should spring from the use of relatively unstructured observational methods. This would allow the capture of a certain amount of data on patients' reactions to their experiences.

Drawing on the literature on patients' satisfaction (e.g. Raphael and Mandeville, 1979), it seemed that observational data should be complemented in two ways. First, I developed an interview schedule to elicit patients' views about their day-to-day experiences of living and being treated and/or 'cared for' in the ward; and the extent to which they found it possible to establish their own routines, close to the kinds of habits they followed when living at home, e.g. regarding times of rising, taking meals, chosen leisure activities; and the importance to the patient of establishing - or not - a lifestyle close to normal while in hospital. Second, I hoped to use a widely-adopted measure of life satisfaction (Neugarten et al., 1961). The pilot study proved both of these quite inappropriate.

The interview was a failure for several reasons. With some patients, there were difficulties of communication, comprehension or both. With many more, it proved surprisingly difficult - given, for example the written account of the success of Raphael and Mandeville's (1979) survey - to elicit patients' opinions. Monosyllabic answers to questions were very common from patients who appeared to have greater potential for being articulate. I conjectured that patients facing an uncertain future from a position of tremendous dependency and

subordination may, understandably, wish to keep all but their most positive feelings to themselves - particularly when their opinions are being sought in a relatively public place, in view and earshot of other patients and, more important, staff (privacy for interviews was virtually impossible to achieve). Further, patients who believe they may be spending a long time on a ward may find that coping with the demands of hospital life are easier if criticisms remain unspoken and unthought. If so, it ceases to be surprising if comments remain at a superficial level: 'All the nurses are angels', but 'The breakfasts come too early'.

The Life Satisfaction Index was experienced as extremely upsetting by several patients - again, perhaps, because of uncertainty over their future conditions of living - and was thus discontinued. During the pilot study I found that data on patients' perspectives on and feelings about their hospital experiences emerged from informal, focussed conversations. For example, by talking with a patient immediately after she had been seen by a doctor doing a ward round, much information was forthcoming on how both doctor and treatment were viewed.

Thus, I concluded that patients' experiences, and their feelings about these, could best be gleaned through observational methods combined with informal conversations about particular incidents arising from day-to-day in the hospital ward.

Observation of patients' experiences

In an exploratory descriptive study, to be carried out in an arena where consensus regarding criteria for judging 'quality' of patients' experiences is largely lacking, it seemed necessary to adopt

an approach to observation which would:

1. Permit fairly detailed qualitative description;
2. Preclude the need to make judgments about the valence of what was being observed to the patient herself at the time of observing;
3. Enable informal conversations to interweave spontaneously with my observations, in order to capture patients' and others' perspectives on what was happening as it happened;
4. Allow flexibility in following sequences of events and interventions through over a period of time when this seemed pertinent.

In other words, a highly structured approach to observation seemed inappropriate for this study. Further, I was not seeking to document with great precision the timing and frequency of all features of patients' ward-based experiences. I felt sacrificing some precision here was worthwhile in order to fulfil aims 1 to 4 above, given that I would be a lone observer. I intended that, as an observer, I would participate in ward work and social relations as little as possible, recognising that engaging in informal conversations could inevitably lead to some participation and unwitting influence on turns of events. How the observer role was negotiated in practice will be described in a later section of the chapter.

What was to be observed? My definitions were deliberately left very fluid. The main components of patient-centred observation are listed in Figure 3.1. In observations where patients were not present, for example at nursing report sessions, (a)·(d) and (f) were, of course, not recorded.

Figure 3.1: Patient-centred observation

1. Time
2. Place
3. Who was involved in any interactions with the patient
4. Who initiated the interaction

Content of observation:

- a) What was the patient doing? (e.g. lying in bed asleep, sitting at a table, eating a meal and talking with another patient, attempting unsuccessfully to attract a nurse's attention, muttering to herself)
- b) What was the content of any conversation going on with, around or about the patient?
- c) What (if anything) was being done to or for, or being planned for the patient by others? (Including any decisions made)
- d) How did the patient appear? (Including physical appearance, e.g. clothes dishevelled, hair uncombed; indications of patient's feelings, e.g. weeping, smiling)
- e) How did any other social actors appear? (e.g. impatient and shouting, laughing and joking)
- f) Any spontaneous reactions by the patient to the event(s) of the observation.

In deciding not to define a priori what I would be observing in any detail, I found in practice that an observation of a patient might comprise one, or several or no actions and/or interactions, involving no others, or several others. One observation might be extremely brief, e.g. a glance at a patient asleep in bed, or continue for some fifteen minutes, e.g. a prolonged series of interactions with and about a patient, occasioned by a consultant's ward round, followed by a conversation about the events between the patient and me.

How was the observation to be done? Data collection sheets, as shown in Figure 3.2, were used. Code numbers and letters were used to denote identity of patients, place of observation and identity of other social actors. Although neither time - nor activity-sampling was used, I wished to build up a picture of what patients' experiences were day to day, and throughout each working day. From the pilot study, I found it was possible to observe up to twelve patients, recording one observation or more every thirty minutes for each. The main reason for deciding on a half-hourly time span was that during the pilot study, a majority of patients spent their time in the day room, and I often found myself forgetting to observe a patient who was in a side ward, and unconscious. The study patients were chosen on the basis of their age - 75 years or more - and length of stay in the ward. I chose the four longest stay patients, the four most recent admissions and the two median patients in terms of length of stay. If a patient died or was discharged during the first week's observing, s/he was replaced in the sample by the next patient of that length-of-stay category. Any patients - up to two - admitted during the first week were added to

Figure 3.2

Observation Data Sheet

Hospital:

Ward:

Date:

Nursing staff on duty:

[illegible]

the sample. A total of 86 patients were observed in eight wards. Some basic information about them is in Appendix A.

As a result of the pilot study, I felt it was possible to derive a view of patients' experiences through observation and informal conversations over a three-week period. During that time I spent at least fifteen days on each ward. Several hours of each day was spent observing patients, such that patients were observed during all periods of the waking day on at least two occasions.

Analysis of observation data. This was done in two stages. The first stage was to identify three 'strategic' patients from each ward, around whom to organise the main account of social relations and patients' experiences ward by ward. The pilot study showed that, while there were many shared experiences among a majority of patients on the ward, there were also considerable individual differences. The extremes of the range of individual differences were to be found in the experiences of those patients who were the most socially isolated and the least socially isolated. Analysis of the first two main study wards followed this pattern also. Thus I decided to ground the inter-ward comparisons in detailed analysis of the experiences of three strategic patients: first, the patient I observed as having the highest proportion of interaction; second, the patient I observed as having the lowest proportion of interactions and third, the median patient of the study group in terms of proportion of interactions. In counting interactions, I included those observations in which I had participated in an interaction. This decision was made on the grounds that such interactions were often initiated by patients, and would probably have been initiated with someone else had I not happened to be at hand: e.g.

requests for fetching belongings from the bedside for a patient in the day room, or providing a second cup of tea at breakfast.

Also, inspection of the data suggested that I interacted most with patients who had the highest levels of interaction with other people; and least with patients who interacted little with others. Thus my interactions were simply reinforcing existing trends in interaction. Since absolute frequencies were less important than relative proportion of interactions which were observed, my interactions with patients were not affecting the rank order of study patients' social isolation.

Having identified three strategic patients, the next task was to examine the content of each observation for evidence of inhumanity, to identify the social actors involved and to trace the process through which inhumane treatment had come about.

Definition and examples of inhumane treatment

1. Primary inhumane treatment featured patients' distress and/or indignity which could be directly attributed to the fact of patients being in hospital rather than to contingencies of their illness. Examples include the practice of seating incontinent female patients, nude from the waist down, on piles of incontinence pads; failing to respond to patients' requests to be taken to the toilet, staff ignoring patients' requests for relief of symptoms, e.g. sleeplessness, coughs; staff talking across a patient as though she were not there.
2. Secondary inhumane treatment featured failure to note and/or to respond to patients' distress on the part of other social actors. The distress in this case was not clearly attributed to the fact of patients' hospitalisation, e.g. distress and pain resulting from illness, worry about the future, grieving over a bereavement.

3. Tertiary inhumane treatment featured discussions about the patient - the patient not being present - couched in terms which denied patients' (or their representatives') rights to participate in decisions affecting their own future, for example whether an application for residential care is to be made.

Besides my assumptions and decisions about the practicability of focussing on poor rather than good treatment and about the possibilities this approach might offer in formulating more precise definition of features of good treatment, there was a third reason for building the analysis around inhumane treatment. As the account of the data will show, I soon discovered that in the 'average' geriatric ward, patients' experiences featured inhumane treatment or the absence of it, rather than anything which might have been speculatively regarded as positive. Staff evaluations of the work in which they were engaged also reflected this: work was seen as physically heavy, sometimes professionally unrewarding and often a continuing battle with shortages of resources and staff to 'make do' in the best way possible. Nurses and other hospital staff are usually experts at 'making do', and seldom complain about intolerable circumstances, thus there is little in the way of widely available and systematic information about the characteristic experiences and social relations of the wards in which they and the patients may sometimes be suffering together. A systematic, non-emotive attempt to document inhumanity and to use this constructively in defining more positive models of care seems long overdue.

Social Relations in Geriatric Wards

The patients' role was assumed to be the central one, and the prime focus of the research was to be on patients' experiences. The literature shows that cognisance must be taken of factors such as resource availability - in the material sense, as well as in the shape of staff - and environment (see for example Rhys Hearn, 1979; Storrs, 1982); but at the same time, as the discussion in Chapter 2 shows, there remain chasms in our understanding of geriatric patients' experiences as created by social processes. The assumption that ward sisters would be among the most important social actors vis à vis patients' experiences seemed a reasonable starting point, given evidence from the literature and my own previous research experience. Thus I needed to know how ward sisters perceived the patients in their wards and how they perceived and defined and orchestrated care-work with patients. This could best be done by means of interviews as well as observation of the sister at work. An open-ended interview schedule was developed, and since it seemed satisfactory in the pilot study, it was used in the main study. The schedule is shown in Appendix B. In practice, I used it as an interview guide rather than a rigid proforma.

Obviously patients' experiences are influenced by social actors other than ward sisters and ward sisters' own behaviours are shaped by a whole range of social processes in which they are engaged. Thus observation of patients' experiences encompassed the entire range of other people who interacted with them, or whose other interactions concerned them. Observing patient-centred interactions was assumed to be crucial to evolving some understanding of patients' experiences in the context of social relations in geriatric wards, in the widest possible sense. As noted earlier, observation of a study patient's

interactions included identification of other social actors and content of any conversation or behaviour, and any indications of their feelings about the interaction. Thus systematic data about patients' social relations was collected through observation.

Besides the ward sister, it seemed from the literature that doctors - in particular consultants - might be key people in relation to patients' experiences. Thus, as with the ward sisters, I aimed to interview consultants about their perceptions of patients and of appropriate care-work, and of the division of labour in, and organisation of care-work. The interview schedule is shown in Appendix C. Consultants' patient-centred interactions could also be observed, but to a more limited degree than was the case with ward sisters, because their ward presence is usually limited.

What of the other social actors, particularly paid professional and ancillary workers who had a regular part to play in the ordering of patients' experiences? My original intention was to develop structured questionnaires which would elicit views about patients, work, ward organisation and social relations by means of highly specific questions, thus building up a multi-dimensional picture of ward social relations and of a range of perspectives on patients' experiences in this context. The pilot study suggested this would not be fruitful, and that I might succeed only in amassing rather ritualised responses through presenting specific questions in the form of a questionnaire. Brown (1973) argues that perceptions of work in pursuit of patient care can, in mental hospitals, vary enormously, depending on the social value and social complexity perceived to inhere in care-work by those who are doing it - this in turn being subject to many direct and indirect

influences (e.g. social stereotypes of mental illness). This argument is pertinent to geriatric care also . To interpret responses to questionnaires, it would in my opinion have been necessary to understand the particular implicit and explicit assumptions about patients and work held by individual respondents. Thus, having discovered through the pilot study that observing social actors interacting with patients and engaging in informal conversations with them provided me with data about individuals' perceptions of patients, of work and of social organisation, I decided to abandon the idea of using questionnaires.

My decision to concentrate on observation and informal conversations in pursuit of data on participants' perceptions of work and social relations gained further support from the literature on old age and ageing. The complexities of theories of ageing, and the multiple and sometimes conflicting ends pursued through state and professional policies focussed primarily on elderly people also seem to be reflected in geriatric wards. In the literature, we find nurse authors like Norton (1965) describing geriatric nursing as the ultimate challenge to the art and science of nursing, while nurse researchers repeatedly show that far from being the pinnacle of status and professionalism in nursing, geriatric nursing is seen to be and in practice found to be the lowest of the low among nursing specialties. But, even within a single ward - as I found in the pilot study - one may find both these extremes. This accords with Brown's opinion (1973) about the crucial importance of how professionals perceive patients and work - people or objects, highly complex or deadly routine?

Research Strategy

Choice of Ward Type

The professional literature on care of the elderly sick in Britain shows that schools of thought on the aims and appropriate organisation of hospital care have evolved in various directions since the emergence of geriatric medicine as a medical specialty. A common contemporary practice assumes that patients' best interests are served through a system often called 'Progressive patient care'. This involves categorising patients into three main groups: acutely ill and/or newly admitted patients for assessment, patients undergoing rehabilitation, with a view to eventual discharge, over a number of months and patients deemed to require long-term hospital care. The first category can be thought of as analagous to acutely ill and/or newly admitted patients to be found on any medical ward. Thus, in my search for a variety of patterns in social relations - which I assumed more likely to be fruitful away from arenas of technological dominance - I decided that I should select wards which were closest to the long-stay category. The pilot ward was of the acute/admission type, and had some influence on my decision. It also seemed a priori very difficult to envisage meaningful comparisons of patients' experiences between wards which, although labelled geriatric, were in fact of very different types. Hence it seemed necessary, in a small-scale study, to try to limit this source of variability.

Gaining access

To maximise potential diversity in patterns of ward social relations and patients' experiences, I decided that the eight study wards should be chosen from eight different hospitals. For practical reasons, and a wish to avoid complicating matters by introducing possible inter-regional

differences in resources, practices and expectations, I decided the research should be located in and around a Midlands conurbation. Cranford and Bramlington wards were both in general hospitals of the same names in two medium sized towns within 20 miles of the conurbation. Gaining access proved to be very straightforward. I wrote to the consultant geriatrician at each hospital, and, following an informal meeting with each of them, they sought agreement from the relevant staff at their respective hospitals, arranged for me to meet these staff including the sister of one of the geriatric wards. Both sisters seemed willing to participate and thus agreed that I could start the research at a time convenient to me.

Access was also straightforward at Eastwood and Norton hospitals, each of them being in a different Health District of the conurbation. Eastwood was a general hospital, the site of my own earlier research (Evers, 1977). The six geriatric wards and day hospital were in a purpose-built, separate unit, in a distant corner of the hospital site, and though I had had little previous contact there, I was still known within the hospital. I gained permission through the nursing hierarchy first of all. With nursing support, I then approached the consultants and other staff. The nursing officer in charge of the unit suggested one particular ward for study, and introduced me to the charge nurse who at once agreed to participate in the research. Norton Hospital was a purpose built geriatric unit. I had had previous working contact with nursing staff of the Health District, who introduced me to the local nursing hierarchy. The on-site nursing officer then sought general agreement to the research on the part of other staff, and identified one particular ward for study.

Access to Shipton, Moorhouse, Heathlands and District Hospitals proved rather complicated. All were sited in the same health district. The first three were all geriatric hospitals, and the District Hospital had a geriatric block. I had had previous working contact with the District Nursing Officer, to whom I made my initial approach. Through him, I met senior nursing management of the geriatric division, who were enthusiastic about the research. The Divisional Nursing Officer sought agreement in principle from the consultants, and decided that I should attend a meeting of all nursing officers in the geriatric division. This I did, and at the meeting a nursing officer voiced objections to the research: namely that I would generate extra work for ward staff, and that, like other researchers she had encountered, she speculated that I too would fail to provide any feedback. The members of the meeting did not agree to allow the research to proceed in their hospitals. But the senior nursing staff had clearly decided that they wished the research to take place. Thus, after the abortive meeting, they approached individual nursing officers and ward sisters on my behalf. I then had informal discussions at each hospital, and there was no objection to my carrying out the research. As at the other hospitals, I stressed that confidentiality would be strictly observed, that the last thing I wished to do was to cause extra work or other difficulties for ward staff and that I would provide a short report of the research within weeks of finishing on each ward.

Fieldwork was carried out during a twelve-month period. I spent about three weeks working on each ward. Immediately after finishing fieldwork on a ward, I spent roughly three weeks on preliminary analysis and preparing a feedback report. Once this had been presented, I then began work on the next study ward.

The research process in each ward

In most cases, I had met not more than one or two of the staff connected with each ward before I actually started work, and none of the patients. In all cases I had met ward sisters. I had told them I wished to be as informal and unobtrusive as possible, but that I was very willing to help with aspects of ward work should they so wish. Ways of getting started varied from ward to ward. Sometimes the ward sister would call all the staff together to introduce me, or she would take me around the ward and tell me about the patients, or she would say in so many words, 'Feel free, help yourself'. In all cases I was made most welcome. Although my wish was to participate as little as possible, my initial offers of help were obviously seen in a very favourable light. In practice, I seldom participated in the work in some wards, but in others I participated a great deal. I made beds, assisted at mealtimes, took patients from wards to other departments and answered the telephone. On the first day, I introduced myself to all the patients and explained what I wished to do, and asked if they agreed to this. This sometimes caused mirth among staff, who told me most of the patients wouldn't understand anyway. I introduced myself to patients' visitors also, explained what I was doing and asked if they objected, which none did. I also introduced myself to all staff and others who came to the ward. Complete introductions often continued over several days because of off-duty arrangements. By the end of the first day I had usually identified the group of ten study patients in the manner described earlier, and thus I was ready to begin observing. I tried to interview the ward sister as early as possible during the research period - usually within a day or two. Having got started in this way,

I then spent several hours each day observing study patients. Besides talking informally with staff, patients and others (e.g. visitors to the ward, voluntary workers) I spent the rest of my days collecting other data, the nature of which I will now summarise.

1. Patient-nurse dependency. The severe limitations of these measures in relation to assessing workload and staffing levels have been noted in Chapter One. However, in view of the potential argument that any inter-ward similarities or differences my data might reveal were attributable to patients' characteristics, I decided to use a simple measure of patient-nurse dependency. The Barr pro-forma was chosen. It is reproduced, together with the scoring system, in Appendix D (Mulligan, 1973). It is straightforward and was found useful in a colleague's study (Fretwell, 1978). It was completed on most days by whichever nurse was in charge of the ward. The pilot study showed that there were two major problems with the Barr checklist. First, it was not designed primarily for use on geriatric wards, and, as such, does not include an item on patients' ability to dress themselves. This has an important impact on workload, since on most geriatric wards almost all patients are up and dressed each day. Where perhaps a substantial number of patients need help - sometimes a great deal - with dressing, this clearly can take up a lot of nursing work time. The second problem was that inter-rater agreement was rather poor. (The nurse in charge of the ward each day was asked to fill in the form, and this was not always the same person). So far as I was able to judge, differences of opinion did not necessarily reflect real changes in a patient's condition or capacity for self-care.

Despite the problems of the dependency checklist, it gives a very rough idea of comparability of patients between one ward and another. Since measuring patient-nurse dependency was only a small facet of the

study, I decided to accept the limitations of the Barr scale. It had one overwhelming advantage: it was extremely quick to complete. I would have been very hesitant about trying to persuade nurses to complete a longer and more complicated proforma.

2. Staffing levels. A note was made of the numbers of all staff - including domestics, remedial therapists, doctors, nurses, social workers etc. usually available to work on study wards. Nurse staffing levels were noted during each day shift for each day of the research. Taken together with the patient-nurse dependency data, nurse staffing levels enabled inter-ward comparisons to be made in the light of relative workload.

3. Professionals' records. In order to discover how patients' hospital histories as well as their current circumstances were defined by professionals, I wanted to study the medical notes, nursing Kardex, and, where available remedial therapy and social work records. I gained permission from all the professionals concerned to have access to patients' files, and I explained to patients and their relatives, as I met them, what I aimed to do in the research, and asked if they were agreeable to this. No-one objected.

I took verbatim extracts from records in the light of extremely broad criteria of potential relevance: that anything evaluating a patients' condition, circumstances, changes or lack of changes, might be important in providing a context for analysing what I observed of patients' experiences and ward social relations. Thus, for example, I noted the entire contents of the nursing Kardex for all study patients for the duration of the research. I also noted what drugs were prescribed for each patient, and how prescribing had varied over the period of the patient's hospitalisation. Likewise, I noted type and incidence of diagnostic and monitoring tests and investigations, and any changes in diagnostic labels.

4. Extra-ward data. I sometimes followed patients out of the ward and observed them in other departments, e.g. physiotherapy, occupational

therapy and the day hospital. This was particularly useful in providing a forum for exploring social relations and patients' experiences with non-nursing staff. Very occasionally I followed professionals outside the hospital in connection with a study patient, for example with an occupational therapist doing a home assessment. This again provided a forum for discovering new angles on how work with patients was perceived by professional and lay people.

5. Consultant interviews. I tried to arrange these as early as possible in the research period of three weeks on each ward, though in practice this was not always possible.

6. Miscellaneous. Informal conversations with non-study patients, and anything pertaining to the ward which I found interesting - and which was not covered under any of the above headings nor by observation of and/or concerning study patients, I recorded in field notes, either during a break in the day's work, or later at home.

After three weeks, I had generally collected observation data for study patients covering all hours of the working day at least twice, as well as the other data listed above. I then withdrew, and after about three weeks presented a report of about a dozen pages, in which I tried to summarise what I had been doing and what I had found: in particular, I discussed the strengths and problems of each ward's general pattern of work from the patients' angle and from the staff's angle. Inevitably, analysis of staff levels and patient dependency were discussed as they were burning topics of concern on all the wards. The reports seemed to be well received, and

it was always possible to find something positive to say in the most dismal of wards, since a majority of nursing staff were strongly committed to doing their best, as they saw it, by the patients.

Having presented the report and met with staff to discuss it if they so wished, I then began the process again in another ward.

Research Problems

Researcher influence and unobtrusiveness

The extent to which my presence and my participation on the wards influenced usual patterns of behaviour is an open question, as in all studies using observational methods. When I was participating in work - e.g. making beds - I was not, clearly, observing patients, though I might well have been talking with the nurse I was helping. Thus when I was observing, I was never at the same time participating in anything other than briefly or sporadically. Reciprocity through participation was essential to creating good relationships with staff, also with some patients who expressed concern about 'their' nurses being overworked. Various pieces of indirect evidence suggested that any influence I might have had was not a dramatic one. Quite often nurses remarked that they hadn't noticed my arrival, presence or departure because they had been too busy. As I went about the ward, dipped into nursing report sessions or case conferences, I seldom noticed any abrupt changes in the work process or in conversations which were going on. I did find, however, that it was more difficult to maintain an unobtrusive role in wards where work routines featured variability. At Heathlands, described in Chapter 6, an attempt had been made to de-routinise patient care. In addition, a majority of patients were mentally alert. In this ward, both staff and patients took a lively interest in the progress of the

the research, and both groups would seek me out to convey pieces of information or opinions, and to ask my opinion about many aspects of ward life. I had to abandon my clip board and data sheets, and use post hoc notes to record data. Thus data from this ward is not directly comparable with the others in the study. In responding to questions or requests, I tried to strike a balance between the need to avoid contaminating my data, and the need to behave as a socially acceptable human being.

Social researcher observing health care professionals at work. My own biography, as that of any social researcher interacting with the subjects of research, posed certain problems which had to be overcome. Never having been a health worker, I lacked basic knowledge which would have been necessary to record and evaluate inhumane treatment in connection with medical, nursing or other technical procedures, yet I became aware of a number of great differences between wards in this area. For example, sometimes patients had been catheterised. There was a variety of nursing practice regarding management of catheterised patients. I observed that on one ward, bladder washouts were done regularly, the nurses saying that this helped to prevent infection. Patients' records suggested that incidence of urinary tract infections was lower than in another ward, where bladder washouts were never done unless onset of infection was actually suspected. Was incidence of infection increased by prevailing practice on the latter ward? Perhaps so. This might have been evaluated as inhumane treatment. There were other examples too. On one ward, if patients were observed going to the toilet more frequently than usual, the nurses would initiate investigations. On another, nothing would be done unless nurses were sure of a full-blown infection, when they would send for the doctor. I decided that evaluating observations such as this required

professional knowledge and could not be judged by me. Fortunately there were few such instances of which I was aware, and my role was in any case that of social researcher.

These disadvantages arising from my own biography were, I felt, handsomely compensated for by various advantages. First, I never posed any kind of threat to those staff I was observing because I was an outsider. This helped with gaining and maintaining access. Second, I was able to ask very basic questions which revealed much about how staff perceived patients and work - why toilet rounds were carried out, why pressure areas were managed in various ways. This I could not have got away with had I been seen as an experienced health worker. Third, those patients who understood what I was doing perhaps tended to see me in a more neutral way, rather than identifying me with 'the hospital'.

Invasion of privacy. Sometimes I sacrificed observational data out of respect for the privacy of patients and their relatives; where distressed relatives were spending time with critically ill patients and where the intimacies of life for mentally orientated but physically dependent patients was concerned. This occurred relatively infrequently.

Stresses of data collection. Inevitably, there were various incidents and interpersonal exchanges which I found either distressing, or which conflicted with my private views of morally acceptable practices. Examples would be the strategies employed in some cases

to constrain individual patients to 'agree' to be sent to an old people's home, or some of the circumstances of patients' suffering and dying which were observed. I took a short break from fieldwork when I felt that my non-judgmental stance was under siege, and in no case was there any evidence to suggest that the research relationship with ward participants had been jeopardised.

I did, however, find the whole research experience depressing; the more so perhaps because as an outside observer I had no sets of tasks with which to busy myself and distract me from what I was seeing. My personal reaction to doing the research made it all the more important to generate a non-emotive analysis of inhumane treatment and its aetiology.

Summary

This chapter has described the basic assumptions - derived from my former research experience, the literature and the pilot study - which guided the development of research methods. The methods used to collect data about patients' experiences and about social relations have been described, as has been the strategy for analysing what I observed of patients' experiences. Crucially, the notion of inhumane treatment has been operationally defined and the reasons for its use have been noted. The research strategy and other sources of relevant data have been described and, finally, research problems and how they were overcome has been discussed. A diary noting the main stages of the research is at Appendix E. The next chapter begins the data analysis by describing and comparing two wards, Cranford and Bramlington.

CHAPTER FOUR

A BASELINE: TWO WARDS COMPARED

The two wards considered in this chapter epitomise different styles of 'patient warehousing', after Miller and Gwynne (1972). Describing and attempting to account for the different characteristics of these two wards will establish a baseline against which the other wards can be compared.

The three 'strategic' study patients from each ward and their experiences will be described. (The rationale for selection of these patients has been noted on p.65, Chapter 3). I will then use other data sources - sisters' and consultants' interviews; their observed work behaviour; patient-nurse dependency and staffing levels - to describe pervasive patterns in defining and organising work. The wards chosen for this baseline analysis are Cranford and Bramlington. Their choice is not meant to reflect any assumptions about their relationship with each other or with the other study wards. They should not necessarily be regarded as representing the extremes of a 'warehousing continuum'. They do, however, feature some obvious contrasts regarding patient care, as the data will show.

Cranford

Some basic characteristics of the eight study wards are shown in Appendix F. Cranford was a traditional 'Nightingale' type of ward, with 29 beds for women patients. The day room had been built on, and was reached by a short walk down a passage from the main bed area. It was not visible from the ward itself. Most of the patients were long-stay.

The strategic patients

Numbers of observations of study patients, and the proportion of observations when patients were alone for Cranford and the other study wards are shown in Appendix A.

Mrs. Elsie Corbett. This patient was alone for a greater proportion of observations than any other study patient. Table 4.1 shows that seven observations featured inhumane treatment. Mrs. Corbett was a widow aged 84, and had been on Cranford Ward for almost four years. She had been transferred from another general hospital about ten miles distant, where she had stayed for about six weeks, following a fall which had fractured her femur. She had never regained her mobility. Before her fall and admission to hospital, she had been living alone in her own house. She had two daughters, according to the nurses: described by them as 'dirty daughters'. One had been married to a former mayor of Cranford, but had become alcoholic and was divorced; the other was a 'woman of the road', known locally for pushing an old pram full of rotting vegetables. The former daughter visited occasionally, and was always accosted for payment of Mrs. Corbett's hairdressing bills. The nurses surmised that Mrs. Corbett must once have been well off: the house she had lived in was large, in a nice part of the town. Nobody seemed to know what had become of her house or any money she might once have had. At the time of her admission to the ward, the GP seemed to regard this as 'the final solution', saying "Thank you for taking this lady ... she lives in awful conditions ..." On admission, the patient had an indwelling catheter, a urinary tract infection and a pressure sore. This healed, and the catheter was dispensed with although Mrs. Corbett remained incontinent. Shortly after admission to Cranford, the medical notes observed "I think she has given up.

TABLE 4.1: CRANFORD WARD STRATEGIC PATIENTS

1. Mrs. Elsie Corbett: Most alone

<u>No. occasions</u>	<u>Primary inhumanity (PI) -6</u>
3	Undressed, then left sitting in nightgown in day room before 3 p.m.
1	Changed into night clothes while sitting on the toilet
1	Being toiletted in public view
1	Spent day sitting in day room with hair tousled, basic personal hygiene unattended to
	<u>Secondary inhumanity (SI) - 1</u>
1	Almost falling out of her chair while asleep; ignored by nurses
	<u>Total</u> = 7 observations

2. Mrs. Bertha Charteris: Least alone

<u>No. occasions</u>	<u>Primary inhumanity (PI) - 10</u>
3	Difficulty walking out of the day room: trolleys left obstructing the passageway
2	Having to get dressed in full view of the ward
2	Anxious about the behaviour of another patient
1	Lack of suitable second course at dinner
1	Was bathed together with another patient (in bathroom with two baths, and no means of securing privacy one from the other)
1	Told not to go to bed by a nurse who decreed it was 'too early'
	<u>Secondary inhumanity (SI) - 11</u>
6	Distress over the prospect of entering residential home: not dealt with by staff
3	Grieving over her dead husband: ignored by staff
1	Grief at news of her sister's death: ignored by staff
1	Distressed behaviour: patient prepares to leave ward, packs case. Reasons for her distress not sought nor addressed
	<u>Tertiary inhumanity (TI) - 5</u>
3	Social worker spoke of patient as if she was an object awaiting dispatch to residential home
1	Patient was denied the opportunity to make her own choice from the menu
1	Relatives excluded from decision as to whether patient should return home while awaiting residential place
	<u>Total</u> = 26 observations

Continued

TABLE 4.1 (Continued)

3.	<u>Mrs. Henrietta Holdsworth</u>	Median
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 26</u>
	11	Problems/distress over getting to the toilet
	6	Expressed distress about her experiences of being in hospital
	3	Constrained to participate in group activity despite reluctance
	2	Being toiletted in public
	2	Being ignored by two staff working with her
	1	Unkempt-looking
	<u>Total</u> = 26 observations	

TLC ('tender loving care' only)". Six months later, she was described as ' Completely demented'. The Orders page of the nursing Kardex did not contain a written diagnosis, but prescribed: "Totally helpless. Wash and dress with help. Four-hourly pressure area care. Oatmeal bath weekly ... Incontinent. Oil feet - dry. Vasogen to hip ... encourage fluids ... walk patient at least once daily".

The basic pattern of Mrs. Corbett's day showed virtually no variety. She appeared totally helpless, including having difficulty with feeding herself. She was unable to talk. Her day consisted of being got up, fed her breakfast, being taken to the day room, toiletted and changed, fed her lunch, toiletted and changed back into her nightie, given her tea, and being put back to bed. The patient spent her days doing nothing. She dozed a great deal, and her main activities were waving both arms aloft, banging her coffee mug on the table, and chewing the corner of her blanket that usually covered her knees. Sometimes she would mutter

unintelligibly. It was impossible to tell anything about how the patient felt, or even know if she felt anything at all about what was happening to her in the ward.

Of 76 observations, seven featured inhumane treatment, as shown in Table 4.1. None featured distress on the part of the patient, but as has been noted, the apparently far advanced state of the patient's dementia made it impossible to judge what the patient might be feeling about her experience in the ward. Three observations show that the patient was usually changed from her day clothes back into her night-clothes before 3 p.m., many hours before returning to bed. She was then generally left sitting in the day room, clad only in a nightie, cardigan and slippers - sometimes a dressing gown. In one observation, the patient looked unkempt, as though her basic physical hygiene and appearance had not been attended to. On one occasion, the patient was toiletted on a commode beside her bed in full view of the ward. On another, the patient had had her clothes changed by a nurse while she was sitting on the toilet. Finally, on one occasion the patient fell asleep while sitting in the day room, and was left unattended while apparently about to slip out of her chair altogether (secondary inhumane treatment).

Mrs. Corbett was at one extreme of the group of study patients with respect to the proportion of observations where she was alone; Mrs. Bertha Charteris was at the other.

Mrs. Bertha Charteris. As Table 4.1 shows, Mrs. Charteris experienced 26 instances of observed inhumane treatment.

At the end of the research period of three weeks, Mrs. Charteris had been in hospital for about a month. Home was a few

miles from Cranford, at the house of her daughter and son-in-law, both in their mid-60s. Her husband had died eight months earlier. It wasn't entirely clear exactly what had precipitated her admission: her daughter talked a lot about the problems of Mrs. Charteris' recent falls at home; the medical notes remarked on her swollen ankles, failing eyesight, pernicious anaemia and occasional incontinence. The nursing Kardex noted her problems on admission to be overweight, decreasing mobility and falls. Physically, the patient was short and fat. She talked quite intelligibly and seemed *compos mentis*. She also seemed anxious and depressed to me. She was able to do most things for herself, though she could walk only slowly, with the aid of a zimmer frame. Her eyesight was poor and she had an appointment for sight testing and new glasses. She wasn't deaf. She had many visitors. I judged that she was well able to form meaningful social relationships with people, though her personal worries and her continuing mourning for the loss of her husband meant that she came over as being a bit reserved and withdrawn.

Mrs. Charteris' day had a pattern to it, dictated by the ward's routines, for example, mealtimes. Like the majority of patients, she spent most of the day in the day room. However, she went to the toilet when she herself chose, and she sometimes left the day room and returned to her bedside during the day. She also put herself to bed in the evenings, though in fact she did this at around the same time as the general 'bedding down' was being done by the nurses. Her dressing and undressing were often done very publicly: she was unable to draw the curtains round her bed unaided, and unless a nurse noticed and did it for her, the curtains remained open. She talked with other

patients, particularly study patient 1, Mrs. Purbright, and sustained a wide range of interactions. She passed the time during the day in various ways. Apart from talking with patient 1 and her visitors, she spent a lot of time going to the toilet: frequently, with each trip taking some time as it was a fair walk from the day room. She also participated in any activities that were going on: e.g. exercises organised by the occupational therapy aide, making Christmas labels for a forthcoming sale of work (also organised by the occupational therapy aide), the weekly cookery morning. She left the ward to visit the physiotherapy department for exercises, and went out to visit a prospective old people's home. She was seen at some length by the consultant during his weekly ward rounds. She watched T.V. sometimes in the evenings.

Out of a total of 109 observations, ten featured primary inhumanity and eleven featured secondary inhumanity. Five further observations featured tertiary inhumane treatment (see p.68 Chapter 3 for definition of inhumane treatment). Primary inhumane treatment included lack of attention to basic privacy; worry over the bizarre behaviour of another patient; lack of a suitable pudding for her (Mrs. Charteris had difficulty swallowing, because of an oesophageal stricture); not being allowed to go to bed when she chose and, on three occasions, Mrs. Charteris had extreme difficulty in negotiating her unsteady, zimmer-supported way from the day room to the toilet because of the position of trolleys which obstructed free passage. Although there were nurses present, nobody thought to move the trolleys.

As Mrs. Charteris was both sensible and mobile, she had the capacity to think about what she wanted to do in the ward, and (sometimes) put it into action: e.g. she was relatively autonomous regarding meeting

her own toileting needs, unlike Mrs. Corbett, who neither knew when she wanted to go, nor was able to do anything about it; and unlike Mrs. Holdsworth (see below), who was painfully aware of her toileting needs, but dependent on help to fulfil them. So patients' mental orientation and physical condition is relevant to the kind of distress they may suffer as a direct result of their experiences in the ward. But as the data analysis proceeds, it will become clear that patients' characteristics are very far from being the whole story when it comes to accounting for their inhumane treatment.

Mrs. Charteris observed to me at one point that "It's not so much that I mind the idea of going into a home, but that they've made me agree to go in - nobody asked me what I wanted to do". She felt completely excluded from and bewildered by the complicated machinations surrounding her possible transition to Part III accommodation. Of eleven instances of secondary inhumane treatment, six had to do with plans for Mrs. Charteris' future. Her signs of distress were not responded to by ward staff. The situation was rather complex. As far as I could understand it, Mrs. Charteris wanted to return to live with her daughter, who had looked after her since her husband died eight months before. The daughter and her husband wanted to have her back, but both were getting on themselves, and lived in a tiny house with an outside toilet - virtually impossible to negotiate with a zimmer frame. Thus they felt they really couldn't cope any more. The consultant and ward sister were making great efforts to counsel the family and help them to come to an equitable agreement about what would be best: at the same time, they didn't want Mrs. Charteris occupying a bed indefinitely. As the days passed, and Mrs. Charteris was taken to visit an old people's home to see what she thought, it seemed as though she might come round to the idea given time. Her daughter didn't want

to have her home till a place came up, saying that if once Mrs. Charteris returned to them, she wouldn't want to leave, and it would all be very traumatic. The consultant was considering asking them to have Mrs. Charteris on a temporary basis as he expected a long wait for a place. Meantime the outside social worker, who'd been involved for only 14 days, decided the hospital were going to 'force' the family to have Mrs. Charteris back, so somehow she engineered the immediate offer of a residential place, arriving one afternoon with Mrs. Charteris' daughter, somewhat bewildered, and a solicitor, to make the necessary arrangements. Mrs. Charteris was very upset by all this, a number of the hospital staff, especially the consultant, felt things had not turned out as well as they should have, and Mrs. Charteris' daughter, too, seemed to feel rather ambivalent when everything suddenly started to move so quickly. Six of the eleven observations of secondary inhumane treatment arose in connection with this. In a further observation, after the encounter with the solicitor and retinue, Mrs. Charteris seemed vaguely distressed and also confused. She packed up all her things, put on her coat and hat, and walked around the ward asking people if they knew the way to Honingford - where she had been living - as she wished to go home. Nobody really took any notice at all. The other four observations of secondary inhumane treatment were to do with bereavement. Three times, Mrs. Charteris became weepy in the evenings, saying how much she missed her husband; and once she was upset because a letter from a relative in Canada informed her of the death of her last surviving sister. No comfort was offered by any of the ward staff.

There were five observations of tertiary inhumane treatment. Four of these had to do with the saga of Part III residential accommodation: the hospital social worker described her as 'a difficult old lady', the

outside social worker told the daughter she wouldn't be able to manage Mrs. Charteris at home, the patient's and family's preferences were not mentioned in discussions about residential care, and the outside social worker made the assumption that the patient would go to residential care without consulting her about it. In the fifth observation, the nurses decided not to bother to ask Mrs. Charteris to make her own selection from the menu card for the following day, but to fill it in themselves.

Mrs. Henrietta Holdsworth. This was the median patient in terms of the proportion of observations when she was alone, As Table 4.1 shows, 26 observations featured inhumane treatment.

At the end of the three-week research period, the patient had been in hospital for about six weeks. She was admitted from home as an emergency (though she had been on the waiting list for three weeks) primarily due to her increasing immobility. This was a serious problem, as the patient lived alone in a flat, and had become very dependent on her neighbour, e.g. to provide meals; also a home help who visited twice weekly. Mrs. Holdsworth had been in the ward less than a year before, for almost three months, as a result of her longstanding congestive cardiac failure (CCF). She was a widow aged 90, and had a son (living away) and a daughter (local) - the latter visited, as also did Mrs. Holdsworth's granddaughter. On admission the medical assessment was "occasionally incontinent of urine; eyesight poor; hearing poor; cannot walk after fracture of femur (three months earlier); ... confused; poor memory; ... speech normal; no wasting of muscles, no loss of tone/movements/sensory loss. Diagnosis: aortic incompetence, CCF, immobility".

The Nursing Orders page of the Kardex, on admission, prescribed physiotherapy and occupational therapy: "mobilise, rehabilitate, assess" (in that order!). Physically, the patient was small and thin. She was able to talk intelligibly, and in the brief conversations I had with her - it was difficult to engage Mrs. Holdsworth in social chat - she seemed *compos mentis* but withdrawn and depressed. She seemed able only to talk about how ill and tired she felt, how she was always hungry, and always anxious about wanting to go to the toilet: all of this hardly surprising, considering her condition. However, I judged that since her capacity for reciprocity was limited by her total preoccupation with her own state, it was unlikely that she would be able to form social relationships with staff which both they and she would find meaningful.

The basic pattern of Mrs. Holdsworth's day showed but little variety. Between 7.45 and 8.30 she would be sitting beside her bed dressing herself, usually not curtained off. Once a week she would remain in bed until well after breakfast, before being bathed. After breakfast had been cleared away, somewhere around 9.30, Mrs. Holdsworth was got to her feet, usually by two nurses, and walked with her rollator to the day room. (Except on bath days, once a week, when she would arrive in the day room perhaps an hour later). There she would sit, receiving coffee from a volunteer or domestic at about 10.30. At about 12.00, lunch arrived, and Mrs. Holdsworth would be helped from her armchair to a table, where she would sit and feed herself. She appeared to have a good appetite, and ate all that was put before her. Sometime between coffee and lunch, she would be taken to the toilet, sometimes in a wheelchair (if Sister was not on duty), sometimes being walked by one or two nurses (if Sister was on duty). She would be taken to the toilet again between afternoon tea (at around 2.30) and 3.30.

At that time she would be undressed and put into her nightie and a cardigan before being returned to the day room. The evening meal was served about 5.00, and sometimes after 6.00 she'd be taken by two nurses, to the toilet, in a wheelchair. After finishing there, she would be put straight into bed, without being offered the chance to wash her hands or anything else. At about 8.30, she would be given a milky drink in bed, after which she would be put on the commode beside the bed, often not curtained off, before being tucked in for the night. Mrs. Holdsworth also received medicines on some of the regular drugs rounds.

Mrs. Holdsworth did very little: she spent most of the time just sitting, often dozing. She did, however, receive visits from some of her family; and the pattern of her life on the ward as just described was also influenced by the routines of non-nursing staff. Both the physiotherapist and occupational therapist came to the ward to mobilise the patient, usually once a day. Mrs. Holdsworth was also reviewed during the weekly ward round.

Much of the primary inhumane treatment Mrs. Holdsworth experienced had to do with a lack of privacy, and her difficulties about getting to the toilet. The following is a typical example.

At 2.30 in the day room, the patient calls: "Nurse, come to me". Nurse McGrath is the only nurse in the room but there is also a voluntary worker present. Nurse: "What do you want?" Patient: "I want to go to the toilet". Nurse: "I can't do anything for you" (because she needs another nurse to help, though she doesn't explain this to the patient). The voluntary worker goes to the patient, who asks her "Do you feel sorry for me?" - "Why, are you poorly?" Patient: "Yes". Volunteer: "Well, then, I feel sorry for you". At 3.00, the patient is still calling

"Nurse ...". Nurse Field is in the dayroom now, along with Nurse McGrath and the volunteer. Study patient No. 1, Mrs. Purbright, observed what is going on, and says "Oooooooooo what a lot of trouble!" One of the nurses says "What do you want, Mrs. Holdsworth?" Do you want to go to the toilet?" Patient: "Yes, but I didn't want to shout it out in front of all these people". They walk with her - and her rollator - while Mrs. Holdsworth protests "Ohhh, it's agony ... will you hold me?" ... can I have a sit-down?" Volunteer: "She's terrible". The nurses make her walk.

Mrs. Holdsworth took a gloomy view of being in hospital, telling me on one occasion: "In hospital you are all fastened up. It's not very exciting is it? Well, I suppose I shouldn't say that ... they look after us very well. I have very good health, thank goodness, what about you? I wish it was tea time ... still, I'd rather it wasn't a cooked meal, I'd far rather have sandwiches. But you can't expect to be looked after individually can you - you've got to be looked after as a whole".

Resumé: The three strategic patients

Routines featured prominently in the day-to-day lives of the three strategic patients. Mrs. Corbett, the most alone of the study patients, who fitted in passively with the routines as managed by the nurses, suffered the least inhumane treatment. Both Mrs. Charteris and Mrs. Holdsworth suffered considerable inhumane treatment. For the former, much of her suffering seemed to arise because her life in the ward was governed by a lesser extent by routines, and featured attempts on the part of staff to develop plans ostensibly contingent on the patient's individual and unique circumstances. Unfortunately, things seemed to misfire somewhat. Mrs. Charteris' distress was not responded to by

staff. They had no routine for dealing with distress, and perhaps felt they could offer her no real comfort and thus coped with the situation by ignoring it. Mrs. Holdsworth's life in the ward was highly routinised, and much of her suffering arose because she did not fit into nurse-initiated toilet routines: she often wanted to go outside the habitual toiletting times, and sometimes did not want to go when a 'toilet round' was in progress. The ward's staff seemed to find it difficult to respond to this patient's particular needs.

I will now take a broader look at ward work processes by turning to data from interviews with the ward sister and consultant, and what I observed of their work behaviour in the ward.

Ward Sister's Interview

First, her perceptions of the ward's patients and their nursing care requirements. The ward's 29 beds are usually full. Patients' length of stay varies, but there isn't much variation in medical diagnoses. Most patients are 'long-stay'. Most are incontinent, two are really senile, some are pretty confused and most are helpless. There is one patient who wanders but no aggressive patients. A few emergencies come into the ward, from home or from a medical ward. There are a few rehabilitation patients, and some patients are discharged but most leave only when they die; though the death rate, i.e. patient throughput, is quite low. Most of the work is basic nursing care; which is after all the fundamental feature of all good nursing. There is a lot of toiletting, which is very heavy work. There are special skills needed in handling old people, both practical (e.g. knowing that one should dress the good side first with a stroke patient) and

psychological (e.g. the techniques of 'reality orientation'; skills in cajoling patients to help themselves). Geriatric nursing is a specialty, and needs a special type of person to do it. It is hard for newcomers to adjust to this kind of work. Most of the work concerns general observation, pressure areas, oral hygiene and basic care. The only technical work is the occasional sterile dressing. Sister finds rehabilitation work rewarding, but also likes long-term care, which brings different kinds of reward: 'It's all caring, preventing pressure sores and keeping people sweet-smelling. You've got nothing to work on'. Most nurses give insufficient attention to individual care, for example every effort should be made to ensure patients have their own clothes. Nurses should "facilitate gracious living so far as is possible here, but community care is always a better option to hospital care". Sister sees it as part of the nurses' work to become involved in therapy, but staffing levels are usually too low to do much over and above 'the basics'. It is important for nurses to be able to judge when they should stop in their efforts to stimulate patients.

Staffing. The ward's staff consists of one full-time sister, three full-time enrolled nurses, about five pupil nurses, one full-time and three part-time nursing auxiliaries. She feels the ward needs a staff nurse, as enrolled nurses are not so good on the management side. The balance between enrolled nurses and auxiliaries is not all that important per se: the individual's characteristics are what matters. She feels eight staff are needed in the mornings, but usually there are about six; and in the evenings four or five are needed. A ward clerk is needed.

Ward layout. A 'Nightingale' ward is very good for observation.

But the ward has some disadvantages: there is insufficient storage space; the day room is too small; wash basins are too high; toilet doors are dangerous. Services to the ward are all satisfactory except sometimes, laundry and kitchen: insufficient laundry, inadequate portions of food.

Sister's objectives. For patients, sister aims to provide the highest possible standards of care, and to make life as normal as possible, with outings and entertainments a regular feature. For staff, she aims to train the nurses. She is not always able to attain her objectives, for she is always battling against the clock.

Organising the work. Things are organised from day to day. Sister feels utterly responsible for the ward, first to herself and then to the nursing officer. She tries to delegate work so that everyone knows what to do, and they only need to refer back with particular problems. She said "We do the Nursing Process here". (In practice, as I observed it, this meant that perhaps more than the usual amount of information was collected about patients, and recorded on the Orders page of the nursing Kardex; that patients were allocated to pairs of nurses each morning; one of the pair being the nurse responsible for writing up the Kardex). Each pair of nurses is allocated to work with about eight patients. Breakfasts are served later on Cranford ward - at about 8.30 - so that the incontinent patients can be got up and made comfortable first. After breakfast, patients are toiletted and dressed, and some of the patients are bathed each day so that each patient has a weekly bath. The occupational therapy aide comes each morning, and there may be an assessment, e.g. of a patient's ability to dress herself. Then there is another

toilet round before the lunch at 12. During the afternoon, the pressure areas of patients in bed are attended to, and others who are up may also have pressure area care on their beds. There is a nursing report session, and nurses may spend part of the afternoon doing projects (e.g. a life history of a patient) or receiving tuition. Patients have tea at 2.00 and at about 2.45 toileting begins again, and the helpless patients are put into their night clothes. The ward is prepared for the night. Drugs rounds are done at 10, 12 and 4.30. After the evening meal, at about 5 p.m., patients are washed and put to bed. They are changed and have pressure area care as needed during the evening. Sister aims to have all nurses working in pairs, one trained and one untrained. She tries to have each nurse work with the same patients over a week, but there are problems of continuity. There is a weekly ward round, and the consultant and senior house officer visit the ward daily. Ward rounds are important for co-ordinating work. Sister sees herself as a member of a team which includes nurses, remedial therapists, doctors and social worker. She thinks it all works pretty well.

Consultant's Interview

1. General philosophy of care. Dr. Pyne had been appointed just under one year before the fieldwork took place, and he had begun a programme of considerable change to the hospital geriatric service in the catchment area. One important general principle is that increasing the turnover rate - so often a major preoccupation of geriatricians - should not be seen as paramount. Rather, you must always remember that patients are human beings, and that very often the goals should be caring rather than curing, though it is of course important to distinguish those cases in which cure is the appropriate goal.

2. Who comes into the ward and how. Patients come in as direct admissions from home: if a GP requests admission (usually as an emergency) then a bed will be provided if possible. Dr. Pyne does not believe that domiciliary visits are necessary in such cases. Some admissions come as transfers from other wards: there is a short waiting list, but patients are usually transferred within a few months. Together with a second consultant, there is a waiting list for admission of about 50 to 60 people. Urgent admissions are never a problem, but the waiting list tells a tale of various problems with the health district geriatric service. Dr. Pyne believes there should be no waiting list, but at the time of the research there were no day hospital places. Domiciliary physiotherapy was too thin on the ground; outpatient clinics had only recently been started; there were problems of an inadequate psychogeriatric service. The waiting list does not reflect a shortage of beds, but inadequacies in other kinds of provision. Day hospital provision is the most urgent problem, and steps are in progress to begin to rectify this. However, given the current realities, Dr. Pyne feels it is important to have a highly flexible admissions policy, and that it is not realistic nor helpful to patients, at this point in the evolution of the service, to operate any very precise notions about appropriate and inappropriate referrals. Basically he will see any patient who is referred to him, and help if he can if there appear to be no available alternatives. In practice this means, for example, that he sometimes takes patients who might be uncontroversially regarded as psychogeriatric cases.

3. The consultant's role in patient care. Dr. Pyne believes that nurses are THE most important people in patient care, both in relation to rehabilitation and remobilisation, and long-term care. A wide range of other resources are necessary: physiotherapy (very good service), occupational therapy (abysmal but developing) social work (pretty good), community nursing (in preparation for discharge) which is likewise good. He believes in a consensus approach to resolving differences of opinions both between professionals and with or within families: it is vital to involve families and patients in decision making where fundamental decisions have to be made regarding a change in the patient's future living arrangements, for example. He sees his role in all this as having at least two main components. First, to provide medical support for the main workers, the nurses. Before he was appointed, the nurses had to rely on a senior house officer (SHO) from general medicine if they wanted anything between the weekly ward rounds. Thus decisions were made by default, and this was inappropriate both for nurses and patients (this happened because the general medical SHOs not surprisingly accorded low priority to requests from the geriatric wards, thus requests tended to be made less and less often). So Dr. Pyne immediately began the practice of visiting the ward each day to ask the nurses if they had any problems. Also, he now has his own SHO (though he was on study leave at the time of the research). His second major role is to facilitate co-ordination among all the people involved with patients. Vis à vis both of these, he doesn't see that there is always - or even often - a medically-based imperative for the consultant to be primus inter pares. However, the reality is that everyone, whether professionals or patients and families, have expectations about the status of doctors, and that professional socialisation still reinforces this. Thus if patient care work is to

be of a high standard, it is vital for the consultant to be seen to be centrally involved - even if at the same time he is delegating many responsibilities to other more appropriate workers. For example long-term care: he is happy to look after long-stay patients, but of course it is the nurses who are the most vital people. So long as current status differentials persist, it is important for him to take an active interest in the care of those patients where there is no obvious regular medical contribution to be made.

4. Patient care in Cranford Ward. It is very hard for a consultant to make any judgments about nursing care in wards, so Dr. Pyne believes. He mentions three sorts of criteria. First, staff commitment and morale. He believes the ward sister to be highly committed to working on the ward, and that staff morale tends to be reasonably good. Second, incidence of complaints from relatives: there are hardly any at all. Third, incidence of pressure sores - particularly relevant where many patients are heavily dependent. The ward has an excellent record: only one patient in the last year developed a pressure sore. The problems for the ward lie not with the nursing staff so much, but other factors: as already noted, a poorly-developed occupational therapy service and lack of day hospital facilities, both of which may have negative repercussions when it comes to getting patients successfully discharged. Another problem lies with the inflexibility of nursing management. They seem not to be sensitive to the special problems of recruiting good staff for geriatric wards: e.g. they have a policy that all auxiliaries must be willing to work anywhere in the hospital, though in practice most are assigned to a specific ward or department. A recent applicant stipulated that she was only willing to work on a geriatric ward, and faced with insistence by nursing administration on their policy, she turned down the offer of appointment.

Key Actors' Work Practices: Ward Sister and Consultant

Ward Sister. The daily routine was in fact much as sister described it. She did indeed allocate particular pairs of nurses to work together with specified patients during the mornings in the way she had described. Often she would herself work as one of a pair, usually along with a pupil nurse. Where there was an even number of nurses on duty she would participate in ward work in a less structured way: spending time with poorly patients, and apparently keeping a general eye on the progress of work. She would also spend quite a bit of time in the office in the mornings - there was no ward clerk, and always a certain amount of administrative work to be done on patients' notes and chasing hotel-keeping services, e.g. laundry, ordering and checking supplies. If on duty, sister would usually do the drugs rounds herself.

Some of the nurses said sister was moody, 'difficult' and interfered too much sometimes. Also, some apparently rather mindless routines had established themselves: the nurses said sister had 'rules' about helpless patients being toiletted at the bedside on commodes when being got ready for bed, the less helpless being taken to the toilet, though at some other times of the day all patients might be either toiletted in the toilets, or at the bedside. The rationale for this seemed obscure to me, also to the nurses whom I consulted for clarification. There were two features which sister spoke of, but which I never observed. No patients received pressure area care on their beds during the afternoons, and no projects nor tuition with pupil nurses took place.

Consultant. He did indeed visit the ward daily, and would see any patient at the nurses' request. Although Dr. Pyne's personal style was very informal, his weekly ward rounds had become Big Events, in that as many nurses as could be spared went around with him, also a geriatric health visitor, a physiotherapist, the clinical teacher and the occupational therapist. He would see and talk to every patient, devoting just as much attention to any medical problems of long-stay patients as to those of patients more likely to be discharged. He would involve the entourage and the patients, very often, in discussing any progress, problems or plans, and he would also make many occasions for explaining disease processes to learner nurses - very useful to me, too! In interview, he said he didn't believe case conferences were a good use of time in many cases, but that they should be reserved for particularly complicated cases, or those where there was missing information. And this indeed was what he did: Mrs. Charteris was the only patient on the ward about whom case conferences were held during the fieldwork period. The relatives and patient were centrally involved, but as has already been described, the outcome was not altogether satisfactory, largely because the field social worker chose to exclude herself from the group discussions, and pre-empted the low-key approach initiated by Dr. Pyne.

Resumé: Patients' Experiences and Ward Work Processes

The ward sister and consultant both expressed concern about patients as individuals, and both stressed the value and validity of long-term care as an important activity alongside rehabilitative and curative work with patients. There was evidence in the work behaviour of both of them, and in the way sister aimed to organise the ward-wide nursing work, that the ward ethos included attention to

individual patients' needs. Yet patients' experiences were significantly shaped by inexorable routines, and there was evidence of inhumane treatment. Mrs. Corbett, the most alone of the study patients, was the least 'engaged' of any with the ward regime. She was entirely passive, and fitted in with nurse-initiated routines. Her inhumane treatment was the least. Mrs. Charteris, the least alone of the study patients, suffered considerable inhumane treatment. Much of this arose in connection with those aspects of her management which were supposed to address her unique needs: the planning of her future after discharge. Further, the ward did not seem to have any routines for responding to patients' distress, and Mrs. Charteris was distressed at times and received no comfort. Other incidents of inhumane treatment showed lack of attention to patients' privacy, and curtailment of patients' freedom of choice and action. Mrs. Holdsworth, the median patient, also suffered inhumane treatment, much of which was due to her failure to fit in with the nurses' routines for dealing with toileting. Could these problems be accounted for by shortages of nursing staff?

Staffing Levels and Patient-Nurse Dependency

Cranford's staff complement was noted on p.96, in the context of the sister's interview. Numbers of staff actually on duty during the research period of three weeks were as follows:

FIGURE 4.1: CRANFORD STAFFING LEVELS

	<u>Average</u>	<u>Maximum</u>	<u>Minimum</u>
Mornings	6.8	8	5
Afternoons	5.5	7	3
Evenings	3.6	6	3

In relation to the sister's views on how many staff were needed (eight in the mornings, four or five in the afternoons, six in the evenings) there was on average a shortage in the mornings and evenings. But sister's expectations were on average met and even exceeded during the afternoons. What of patient dependency? All 29 of Cranford's patients were rated as Care Group 2 (of 3): needing considerable help with basic care.¹ So, given that the ward is on average short of staff in relation to the numbers sister judges necessary, it is quite possible that Cranford's problems can be attributed to staff shortages. Yet the work practices associated with inhumane treatment did not change when the ward was relatively well-off for staff. Mrs. Holdsworth suffered problems about toileting whether there were few or many nurses on duty. This suggests that staff levels alone do not account for pervasive and habitual work practices. Comparisons of work processes, workload and staffing levels with other wards as my analysis develops, will also show that the assumption of poor staffing levels accounting for all ills, is largely untenable. But on the basis of this single case study, it cannot for the moment be rejected.

Cranford: Conclusion

On p.44 of Chapter 2, I summarised two models of institutional care defined by Miller and Gwynne (1972): the 'warehousing' and the 'horticultural' model. Patients' experiences at Cranford seem largely in accord with the warehousing model. The regime is geared to the majority patient population: long-stay patients who will not leave the ward until they die. In practice, preoccupation with physical care dominates, and, although basic rights such as privacy are not always preserved, there is evidence that physical care is well done: e.g.

¹See Appendix D for details of dependency checklist

pressure sores are a great rarity. Although lip-service is paid to making life as normal as possible (ward sister's interview) patients in practice are fitted into hospital-devised routines. When they don't fit, this is obstructive, and patients suffer inhumane treatment: e.g. Mrs. Holdsworth's toileting problems. There are no routines for dealing with patients' distress (Mrs. Charteris, for example). Ignoring this may be an act of self-preservation on the part of nurses who might themselves feel distressed that they have little by way of constructive comfort to offer distressed patients. Concentrating overwhelmingly on physical needs through routines which, for their functioning, require patients to be passive, denies patients' status as individual people rather than work objects. Yet Cranford departs from the warehousing model in two important respects. First, the key actors, consultant and ward sister, both believe that caring for long-stay patients who will leave when they die is just as important and necessary as carrying out rehabilitative and curative work. Second, their work practices reflect this, and patients' experiences of warehousing are in some cases mediated by attention to their individual characteristics. Although there were many unintended negative aspects to it, the case of Mrs. Charteris and the plans for her move to residential accommodation featured attention to personal needs of both patient and family. Looking to some of the other study patients who have not been discussed here, there were other examples of a personal approach to patient care: Mrs. Charteris, that is, was not an exceptional case. Mrs. Emily Horobin, for instance, was a patient whose level of confusion fluctuated. On her 'worse' days, she would often become agitated and weepy. Distraction was usually effective in cheering her up, and often a nurse would be designated to "talk to Emily", or one of the regular visitors from the local school would be asked to sit and chat with her. The model of care exemplified by Cranford Ward can be

described as Personal Warehousing. This model will be compared and contrasted with Minimal Warehousing as the analysis proceeds. The next ward to be discussed, Bramlington, is an example of a minimal warehousing ward.

Bramlington

Some basic characteristics of all eight study wards are shown in Appendix F. Bramlington had 32 female beds in two wings, each of a 'Nightingale' type of design. The most demented patients were grouped in one of the wings, which had a small day area, and the remainder of the patients occupied the other wing. Almost all patients were long-stay.

The strategic patients

Numbers of observations of study patients and proportion of observations when patients were alone, are to be found in Appendix A, for all eight study wards.

Mrs. Florence Batchelor. This patient was alone for a greater proportion of observations than any other study patient. Table 4.2 shows that seven observations featured inhumane treatment. Mrs. Batchelor was 92 years old, and had been in hospital for 14 years. The reasons for her admission and prolonged sojourn seemed lost in the mists of time and illegible, fading piles of medical notes. The patient herself, although she seemed entirely mentally alert, did not wish to talk about herself: she seemed depressed and indeed said she felt depressed, unwell and wished only to die. The nursing Kardex was traceable back to six years before the start of my fieldwork, and stated the diagnosis as cerebrovascular accident (CVA) and pulmonary embolism. Mrs. Batchelor's bed was on the left wing of the ward, which housed the 'better' patients.

Although she was very much a long-term patient, she was as already noted, mentally alert. Mrs. Batchelor was wheelchair-bound, but able to move around at will, to dress herself with minimal assistance, and to go to the lavatory unaided. She dressed herself straight after breakfast usually, this operation taking her a long time. At about mid-morning, she would be ready, and take herself to the day room, where she always sat next to the same patient. The two of them shared many conversations, though neither really warmed to socialising before the early afternoon. Both were readers of books, newspapers and magazines, and Mrs. Batchelor and her companion were two of the very few patients who actively watched the television. Mrs. Batchelor also knitted, dishcloth style, but without obvious interest. Mrs. Batchelor would spend the whole day in the day room, getting herself ready for bed very soon after the evening meal was finished at around 5.30.

Mrs. Batchelor suffered the least inhumane treatment of the three survey patients. There were five instances of primary inhumanity, as shown in Table 4.2; and two of secondary inhumane treatment.

Mrs. Ada Parker. This patient was the least alone of the study patients in Bramlington Ward.

Table 4.2 shows that 27 observations featured inhumane treatment. Mrs. Parker had been in hospital only five days at the commencement of my three weeks' fieldwork. She had been admitted from home, following a domiciliary assessment prompted by a geriatric health visitor's request via the GP. Home was a warden-supervised flat, and Mrs. Parker had been unable to walk for seven days. It seems she had possibly suffered a series of minor strokes, which had exacerbated mobility problems, dating back more than two years, caused by troubles from a pinned fractured femur which was thought not to have healed properly. She was further said to be blind in one eye, slightly incontinent of urine and suffering from ischaemic heart disease from

TABLE 4.2: BRAMLINGTON WARD STRATEGIC PATIENTS*

1. Mrs. Florence Batchelor Most alone

No. occasions

Primary inhumanity (PI) - 5

2	Dressing or undressing in full view of the ward
1	Found the food inedible
1	Interrupted while watching TV by nurse turning the sound off
1	Left sitting in a draught

Secondary inhumanity (SI) - 2

1	Looked miserable but was ignored
1	Felt unwell, said she wants to die, but was ignored

Total = 7 observations

2. Mrs. Ada Parker Least alone

No. occasions

Primary inhumanity (PI) - 25

8	Desperate to go to the toilet
7	Being toiletted on the commode in full view of the ward
4	Seated, naked from waist down, on incontinence pad, with only a rug over her knee
1	Cleanliness not attended to after going to the toilet
1	A visitor had to stand because no chair available in day room
1	Chair placed so as to preclude continuing a conversation with another patient
1	Left sitting in a draught
1	Insufficient food available
1	Complained of being fed up with sitting down

Secondary inhumanity (SI) - 2

2	Depressed about lack of progress with walking: ignored by staff
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Total = 27 observations

* See Appendix G for frequencies of inhumane treatment of strategic patients of all eight study wards.

Continued

TABLE 4.2 (Continued)

3.	<u>Mrs. Carrie Carter</u>	Median
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 13</u>
	5	Seated, naked from waist down, on incontinence pad, with only a rug over the knees
	3	Being toiletted on the commode in full view of the ward
	2	Being strip-washed in full view of the ward
	1	Left unattended after incontinence episode
	1	Hot meal placed in front of patient while she slept
	1	Not allowed to go to bed when she wished
		<u>Secondary inhumanity (SI) -3</u>
	3	Looked anxious and miserable - ignored by staff
	<u>Total</u> = 16 observations	

'chronic brain syndrome'. At the time of admission, the explicit aim was remobilisation and discharge home. Mrs. Parker was walked twice a day by the physiotherapist, and her case discussed at great length at the weekly case conference. Her next of kin, a niece living some 30 miles away, expressed the view that Mrs. Parker should spend the rest of her days in hospital, but everyone else thought otherwise, including Mrs. Parker. Mrs. Parker's daily routine was influenced by her designation as a rehabilitation patient and the location of her bed in the left-hand wing of the ward. The left wing had its own day room. Staff were more accessible in the left wing day room, and more of the visitors to the ward made for this day room, both the professionals like physiotherapists, and also patients' visitors: more of these patients received visitors. Thus there was a higher level of activity, and more goings on for patients to participate in or just to observe.

Because she was a rehabilitation patient, Mrs. Parker was generally got up soon after breakfast, to be ready for the physiotherapist's visit. She was seldom put back to bed until after the evening meal. Immobile patients such as Mrs. Parker tended to be toiletted more regularly on the left-hand wing than patients on the right-hand wing. Mrs. Parker did seem confused at times, but on occasions she appeared perfectly lucid. She was very demanding, voicing frequent requests of all sorts to whoever was near at hand. She was however also very charming, in an ingenuous kind of way, and effusive in her praise for the nurses. Thus some of her demands were indulged, though seldom immediately. Mrs. Parker was certainly capable of forming meaningful social relationships, and she sustained a relatively high level of purely social interactions with nurses, and also a few with other patients. Despite her somewhat favoured status, Mrs. Parker scored a formidable level of inhumane treatment: 25 instances of primary inhumanity and two of secondary inhumanity.

A common kind of inhumane treatment of Mrs. Parker was being toiletted in public, i.e. seated on a commode in the middle of the ward, in company with up to four other patients also seated on commodes. For Mrs. Parker, there were seven of these observations. On eight occasions, Mrs. Parker said she was desperate either to go to the lavatory or to be brought a bedpan. On none of these occasions was her request attended to without a long delay. Although said to be only slightly incontinent, Mrs. Parker was seated naked from the waist down on a pile of incontinent pads. This was noted four times in the observation data. The logic of routinely delaying response to a request to go to the lavatory from a patient with continence difficulty, however slight, seems obscure.

Mrs. Carrie Carter. This was the median patient in terms of the proportion of observations when she was alone. Table 4.2 shows she suffered 16 instances of inhumane treatment.

Mrs. Carter was a widow who had been admitted to Bramlington about six weeks before I began my three-week period of research. She had been admitted from home, where she lived with her son-in-law who had been looking after her. The admission, according to the medical notes, was due to the son-in-law's inability to cope with the consequences of Mrs. Carter's dementia. She had been in hospital earlier in the same year, under another consultant, but the discharge home had been impossible to sustain, even with the help of the district nurse. The patient also suffered from diabetes, and the nursing Kardex entry on admission noted that she was incontinent. Although she could talk, the content of Mrs. Carter's conversations was often unintelligible. She was probably unable to enter any kind of reciprocal social relationship. She was unable to get about unaided. Her son-in-law visited her each afternoon. The ward staff described him as strange and unpredictable, and reported that he had been abusive and physically aggressive towards them on several occasions. I never succeeded in engaging him in conversation. Mrs. Carter's days were all much the same. She would have breakfast in bed at around 8 a.m., and would be got up and dressed somewhere between 8.30 and 12. After the midday meal, she might or might not be toiletted, after which she would continue to sit in her geriatric chair in a small day room, until being put back to bed, any time after 3.30. She looked slightly anxious a lot of the time, but none of the ward staff apparently took any notice of this. Her bed was located in the right-hand wing of the ward, along with other patients who were very demented. There were 13 instances of primary inhumane treatment. Eleven of these 13 feature indecency and inattention

to privacy and dignity. A common practice on the ward, to which no exception was made for Mrs. Carter, was to seat patients on piles on of incontinence pads and to leave them without knickers, and with their skirts hitched up around their waists. They were then draped with rugs to cover their nakedness, but very often the rugs slipped to the floor and some time elapsed before anyone retrieved them. Twice I observed Mrs. Carter being washed in public view, and three times she was seated on the commode in public. On one occasion she had soiled herself while sitting in her chair, and some time elapsed before anyone took action. There were three instances of secondary inhumane treatment: Mrs. Carter looked far more anxious and miserable than usual on each of three occasions, but this was apparently not noticed by the staff.

Resumé: The three strategic patients

Routines featured prominently in the daily lives of the three strategic patients. Mrs. Batchelor, the most alone of the study patients, suffered the least inhumane treatment. That she was independently mobile (in a wheel chair) and continent meant that she was able to avoid the inhumane treatment suffered by both Mrs. Parker and Mrs. Carter with respect to toileting needs. Her low level of 'engagement' with the ward routines probably served to protect her somewhat from inhumane treatment. The inhumane treatment experienced by Mrs. Parker and Mrs. Carter showed evidence of a failure of ward practices to preserve basic human dignity; for example in their habitual responses to patients' toileting needs and possible incontinence.

Ward Sister's Interview

First, her perceptions of the ward's patients and their nursing

care requirements. The ward's 32 beds are usually full. The patients on the ward at the time of the research are fairly typical. All the patients are long-stay, apart from those in six rehabilitation beds and one holiday relief bed. Until less than a year ago, all the beds were occupied by long-stay patients. The ward used to get "all the rubbish, and patients only went out in tin boxes". It cheers the staff up to see some of the patients being discharged. Most of the patients come from other wards, but some are direct admissions following domiciliary visits. The nursing work is mainly basic care. There is very seldom any technical work. Sister says she doesn't really experience any difficulties in managing any of the types of patient the ward looks after. Despite her prognostications about "tin boxes", sister says she can never predict how things will turn out for particular patients when they are first admitted: "Sometimes you think they are going to die and they go home, sometimes you think they'll get home and they die". She sees geriatric nursing as a specialty within nursing because it is mainly basic work, and you need a 'special feeling' for the work. This special feeling seemed to be something sister had never thought about before, and she was unable to say anything about what it might consist of, even with prompting from me. Nurses don't get involved with the work of therapists, other than to discuss what they are doing with patients and why.

Staffing. Besides sister, the ward's staff consists of four part-time enrolled nurses, two full-time and seven part-time nursing auxiliaries. There is also one pupil nurse, though more usually the ward has two or three. The ward is short of staff. Six are needed in the mornings, four in the afternoon. A problem arising because so many of the staff are part-time is that very often there is just one nurse on the ward between 2 and 3 p.m.

Ward layout and resources. Because the ward is divided into two wings, observation is difficult. But within each wing, the layout is satisfactory, but rather cramped and lacking adequate storage space. Equipment is inadequate. The ripple beds are not used because they are always breaking down, and sheepskins are not used either because of laundry problems. The ward needs a permanent net bed of its own, and more aids for lifting heavy and helpless patients.

Other staff and ward services. There are not enough physiotherapists, and too many occupational therapists: sister is not sure exactly what they do. They have their office on the ward but serve the whole hospital from it. Thus they are often about on the ward, but very seldom do any actual work there. Speech therapy is virtually non-existent, and there is almost no social work involvement. Chiropody too is a problem, and the hairdresser who is supposed to visit fortnightly has not attended for a long time. Portering and pharmacy services are exceptionally good; other ward services are adequate.

Sister's objectives. It seemed to me that sister had never consciously thought about this before, and was unable to comment. When asked how she felt about her day's work when she got home sister said she usually feels she has been unable to do all the things that she would have liked for the patients. She thinks physical care is just about adequate, but social care is totally lacking. Patients just sit and watch TV all afternoon. Staff probably feel tired and frustrated much of the time, as she herself does. More staff and fewer beds are needed if any improvements are to be achieved.

Organising the work. Sister feels she has a good deal of autonomy in this. She feels vaguely responsible to the Nursing Officer, "who tells you off if there are dead flowers about". She doesn't plan ahead, but

works from one day to the next. I was unable to elicit from her any description of how she organised the work. She said everyone does everything, apart from any dressings which are done by enrolled or pupil nurses. If there are enough nurses, which there seldom are, sister divides them into two teams to work on the two wings of the ward. She says she sees herself as a member of a team, but often feels it is the nurses versus the rest. The most important people to be on good terms with are the domestics.

Consultant's Interview

1. General philosophy of geriatric care. Dr. Cotman had been in post for many years, and was just over a year away from retirement. There were many features of the geriatric unit with which he felt dissatisfied, but which he has been unable to change substantially. He believes that a majority of patients could and should be cared for in their own homes, but acknowledges that a prime reason for their sojourn in hospital is their need for nursing care which in practice cannot be provided to the required level in other settings. Another reason for prolonged hospitalisation of disabled old people is that it is more socially acceptable to them and/or their families to be labelled as 'sick' than as disabled. Also, to live in an old people's home would cost them money: hospital is free. Given these caveats, Dr. Cotman feels that the hospital should be providing as homely an atmosphere as possible, and opportunities for providing some sort of stimulation for those patients who want it and who would benefit from it.

2. Who comes into the ward and how. This ward is primarily long-stay, and most admissions are transfers from other wards. However there are

also some direct admissions - though not of emergency cases - and regular holiday relief admissions. There is a waiting list, and about 30 more long-stay beds are needed.

3. The consultant's role in patient care. Dr. Cotman considers that a geriatrician needs a certain amount of special knowledge, but no special clinical skills. What sets geriatrics apart from other specialties is the need to devote considerable time to co-ordinating a multi-disciplinary team. The most important semi-formal way of achieving this is through the weekly case conference. Hospital and community health and social work professionals meet together to discuss new admissions, requests for admission, possibilities of discharge, holiday admissions and so forth. Usually only a few patients from each of the three wards comprising the unit are discussed. Dr. Cotman also holds a weekly ward round, but sees only those patients whose cases might be described as 'active'. He has one SHO, and a number of GP clinical assistants are responsible for the day-to-day care of patients. Dr. Cotman feels the consultant's role is very important in relation to battling for better resources and better co-ordination all round.

4. Patient care in Bramlington Ward. Dr. Cotman feels that wards should offer a homely environment and opportunities for stimulation. The ward sister should know everything about patients: social, medical and environmental details. She should have a lot of autonomy, and the capacity to initiate things on her own account, particularly in relation to long-stay care. He is able to make judgments about the ward through working with the staff - visiting the ward, and sharing case conferences with nursing staff among others - and by just observing what the ward and patients look like. He believes there are many.

problems concerning the ward. First, its physical characteristics make it virtually impossible to create a home-like environment and to avoid seating patients around the walls in serried ranks. Closing some beds might make more space and create some new opportunities in this respect, but this is quite impossible because of the demand for long-stay care. Opportunities for creating a stimulating environment likewise are virtually nil, he feels. Patients lack freedom of choice, but then many have reached the stage where they would be unable to exercise choice anyway. Possibly their decline could have been slowed or even reversed had a more stimulating environment been on offer in the first place. Related to this problem is the virtually complete lack of remedial therapy services to the ward. Occupational therapists and physiotherapists tend to be almost completely taken over by the rest of the hospital, and devote very little time to geriatric patients. Patients tend to come in and slowly get worse - many might be remediable. The medical staffing situation needs to be improved also: care by GPs tends to be unsatisfactory because of virtually insurmountable logistical problems in maintaining any kind of communication, and, although he has had some very good SHO's, a better arrangement would result through integration with the rest of the hospital, such that SHO's rotated through the geriatric department alongside other specialties. But for this to happen, it would be necessary for the department to accept emergency admissions from casualty directly. At present this would be very difficult, given that the department is barely managing to meet the basic physical requirements of its current patients.

Key Actors' Work Practices: Ward Sister and Consultant

Ward Sister. I had been unable to elicit any sort of description of how she organised work from day to day, other than that everyone knows what the routine is. Although she had said that she preferred to divide the nurses into two teams, in practice this rarely happened. Sister participated in all the work, though in a serendipitous fashion - she spent quite a lot of time sitting in the office or the nurses' small rest room, doing paperwork, e.g. writing the nursing Kardex. She usually did the drugs, also orchestrated the service of patients' meals. The rest of the nurses tried to avoid asking sister 'for a lift', even if she was the only other nurse around at the time. She was not popular: she was seen as lazy, not caring about her patients or her staff, and responsible for deteriorating standards of care, e.g. prior to her elevation to sister, on the retirement of the sister who had been on the ward for years, all patients were said to have been offered a bath at least once a week. Now, because sister was seen as not pulling her weight, it was very difficult to manage to do any baths except in dire need, e.g. for patients who soiled themselves. There was a part-time ward clerk at Bramlington. Despite less office work than at Cranford, the sister spent more of her time in the office. There were never any nursing report sessions on this ward, with the exception of quick hand-over reports between one nurse and another at a change of shift.

There was no obvious work co-ordination, and work routines often broke down. After breakfast in bed, many patients would be unattended for two or three hours while the nurses were working in the other wing of the ward. Usually the last patients would be got up just before lunch arrived at about 12. As sister had said, the domestics were vital:

their goodwill in carrying out tasks not officially their responsibility ensured that physical task accomplishment was completed. After lunch, the patients of the left-hand wing of the ward - the so-called rehabilitation patients - would usually be toiletted, in groups of four seated together on commodes in the middle of the ward. Very often the patients on the other wing were not taken to the toilet at all, but remained seated on their incontinence pads. Between 2 and 3 p.m. all activity ceased: very often there was just one nurse on the ward, and a lone nurse was unable to help most of the ward's patients with getting to the toilet. At 3 p.m. the process of returning patients to bed would begin. The afternoon nurses usually had not been on duty in the morning, and, since there were no detailed report sessions, it often happened that the last patients up were the first to go back to bed, for no obvious nursing care reason. A minority of patients, like Mrs. Batchelor, who were relatively autonomous regarding self-care, had some choice about when they got up and returned to bed.

The consultant. Dr. Cotman's part in ward work as observed during the research, fitted closely with how he himself described it. His visit to the ward generally concerned only a small number of patients, whose cases were active. The weekly case conferences were very informal, friendly affairs. Again, just patients selected by Dr. Cotman or any of the other participants were discussed. Sometimes the patients themselves were invited, but this could have been rather intimidating, since it was a very large group: sisters from three wards, Dr. Cotman and his SHO, two physiotherapists, two occupational therapists, three home help organisers, a couple of geriatric health visitors and maybe some community nurses too. As a team effort, these case conferences were quite impressive. Although

Dr. Cotman was certainly the conductor, he was seldom the sole, or even the main decision maker. Mrs. Ada Parker was the only patient from Bramlington Ward who was discussed at any of the geriatric unit case conferences which took place during the research period of three weeks. She was not herself present, and no decisions were made about her.

Resumé: Patients' experiences and ward work processes

The ward sister was apparently unable to articulate her objectives and to describe the work process. Work 'just happened' - this was borne out by my observation - and care problems, defined as inadequate social care by the ward sister, were attributed to shortages of staff. From what I observed of patients' experiences and inhumane treatment, it was not only social care which could be found wanting: physical care routines embodied humiliation for patients (public toileting, seating half-naked patients all day on incontinence pads) and frequently failed altogether: the women in the right-hand wing of the ward sometimes were not taken to the toilet throughout an entire day. Assuredly the presence of a lone nurse on the ward for an hour after lunch contributed to this, but it also happened when more than one nurse was on duty. No patients were bathed at all during the study period. There was almost no evidence of attention to patients' individuality and distinctive needs.

The consultant took a pessimistic view of Bramlington ward and the plight of long-stay patients. He seemed to believe such patients would really be better cared for elsewhere. He was very concerned about the situation but seemed to feel it was impossible to bring about any improvements without fundamental changes such as many more long-stay beds,

or conversion of the geriatric service to feature more perceptible turnover. His involvement with long-stay patients was virtually nil.

There was much evidence of inhumane treatment of patients at Bramlington. Mrs. Batchelor, least 'engaged' with the ward's routines, suffered the least; but there was no evidence that she enjoyed any positive quality of life. Indeed, she said that she felt depressed and wished only to die. Mrs. Carter and Mrs. Parker both suffered considerable inhumane treatment, much of which featured very basic affronts to human dignity.

The nurses too were locked into this system of humiliating routines. Many of them told me how appalling they felt the ward was. They attributed the problems first to inadequate staffing and lack of support from nursing management whom they saw as totally ineffectual in bidding for improved resources against the requirements of other specialties; but also they blamed the ward's sister for demonstrating too little concern for her patients and her staff. Could Bramlington's problems be accounted for by its inadequate staffing levels?

Staffing levels and patient-nurse dependency

The staff at Bramlington are noted on p.114 in the context of the sister's interview. Numbers of staff actually on duty were as follows:

FIGURE 4.2: BRAMLINGTON STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	4.5	7	3
Afternoons (after 3 p.m.)	4.3	7	3
Evenings	3.4	4	3

On average, then, there was indeed a shortfall in relation to the staff sister said the ward needed, except during the afternoons. Looking back to the staffing levels at Cranford (p.104, also Appendix H which shows the staffing levels for all eight study wards), Bramlington is on average worse off for staff. But the gap between the sister's stated requirements and the reality was similar in both wards. That is, Sister Cranford judged that she needed more staff than did Sister Bramlington. But expectations may derive as much from accustomed staff levels as from judgements about work requirements, thus Cranford's higher expectations may follow from the slightly more generous staff levels.

Bramlington's workload was probably consistently heavier than Cranford's. There were 32 beds, and sometimes all patients were rated as care group 2 (needing considerable help with basic care), but very often three or four were judged to be care group 3: the category requiring the greatest amount of physical nursing work. (See Appendix D)

Is it the case, then, that Bramlington's staffing/workload plight accounts for the worst of the inhumane treatment, i.e. the way that patients were indecently dressed, and the way that nurses managed the toileting arrangements? The answer to this seems to be no, although the question will be reviewed as data from other wards are presented. If it was the case that these examples of inhumane treatment could be attributed solely or mainly to inadequate nurse staffing levels, then a reasonable hypothesis would be that on those occasions where staffing levels met or exceeded the ward sister's rule-of-thumb regarding how many nurses she judged necessary, then observed incidents of these 'bad practices' would be fewer. This was not the case. Indecent appearance and mass public toileting could be observed regardless of the numbers of nurses on duty. Possibly the routines of the ward had developed in response to times of staffing famine, and had become so entrenched, due

to lack of any great (apparent) concern with trying to personalise patient care, that in times of relative feast, no change in styles or priorities of work could be consciously considered let alone practised.

Bramlington: Conclusion

As at Cranford, patients' experiences are largely in accord with the 'warehousing' model of institutional care defined by Miller and Gwynne (1972), which I summarised on p.43 of Chapter 2, and referred to again on p.107 of this chapter. But there are some differences between Bramlington and Cranford. Both feature preoccupation with physical care, but at Bramlington even the physical care routines seem to be wanting at times. Unlike Cranford, Bramlington did not seem to incorporate any systematic attention to patients as individuals, i.e. there were virtually no observable attempts to personalise patient care. Bramlington can be described as a Minimal Warehousing ward.

Cranford and Bramlington Compared

As case studies, the accounts of patients' experiences in two wards illustrate the complexity of pinpointing common and contrasting practices in the management of social relations in the wards, and relating these to patients' experiences. From the analysis so far, I remain suspicious about attributing all problems to shortages of staff. The nature of inhumane treatment experienced by patients in the two wards differs somewhat: fundamental affronts to basic physical integrity of human beings were more prominent at Bramlington than at Cranford. In both wards the patients who were more alone, i.e. least engaged in the ward's routines, suffered the least inhumane treatment. Cranford featured some evidence of attempts to personalise patient care - even though this did not always (Mrs. Charteris) quite turn out

as hoped. There was no evidence of personalised care at Bramlington, thus patients enjoyed no individual protection from ward-wide routines, geared to accomplishing physical care, which frequently broke down. These differences have led me to apply the label Personal Warehousing to Cranford; Minimal Warehousing to Bramlington. If staffing levels cannot altogether account for the observed differences in work practices, what other explanations are possible?

The contrasting beliefs and work practices of ward sisters and consultants of the two wards seem important. At Cranford, both expressed respect for the rights of the individual, and aspired to providing personalised patient care. Long-term care was seen by both as an important job, as important as the care of any other category of patient. The consultant believed the nurses to be the appropriate prime carers, but recognised that, in a medically-dominated and cure-orientated hospital environment, it was vital for him to take an active interest in long-term patients if their care was in practice to be accorded any priority, and not simply relegated to becoming a product of batch-processing routines. Their practices reflected their beliefs, though both ward sister and consultant were quick to acknowledge the many problems they had not yet solved in their attempts to provide personal care for all geriatric patients. The consultant was readily available and provided regular support to the nurses; as well as having regular contact with all the patients.

This contrasts starkly with Bramlington, where personalised patient care was conspicuous by its absence. The ward sister appeared to occupy the authoritative nursing role on the ward without any thought as to the aims and processes of the nursing care of patients. She described long-term patients as "rubbish". The consultant was clearly concerned about long-stay patients, but at the same time profoundly

pessimistic about the chances of improving things. He had in effect opted out of involvement in long-stay care, and the nurses were, by default, in charge without even being aware that this was so.

As the analysis proceeds, I will build upon the argument that the nature of inhumane treatment experienced by patients in predominantly long-stay geriatric wards can be more clearly understood by examining the attitudes and work practices of key professionals: ward sister and consultant. The next chapter will present the data from four more wards. At the end of that chapter, I shall summarise the defining characteristics of Personal Warehousing and Minimal Warehousing models of care.

CHAPTER FIVE

FOUR FURTHER WARDS: DEVELOPMENT AND TESTING OF IDEAS

This chapter develops the analysis begun in Chapter 4. Each of four wards will be discussed in turn. The experiences of the three strategic patients from each ward will be described. Ward sister and consultant interview data will be summarised, and set against what I observed of work practices in the wards. Patient-nurse dependency data will be considered in relation to staffing levels.

Shipton

Shipton was a female ward with 34 beds, in a geriatric hospital located at the periphery of the city. The beds were arranged in cubicles of four. Most of the patients were long-stay, but a few were candidates for short or medium term stay and discharge. There were also regular holiday relief admissions and rotating admissions. Appendix F summarises some basic characteristics of all eight study wards.

The strategic patients

Mrs. Emily Manfield. Table 5.1 shows that Mrs. Manfield, who was the 'most alone' of the study patients, was seen to experience inhumane treatment on twelve occasions.

She was 86 years old, and had been in hospital for five and a half years. She had been admitted from home, the medical notes stating that she had been neglecting herself since the death of her husband, and had refused all offers of help. She was diagnosed to be suffering from "senile dementia with self-neglect creating a social

problem". Three months after admission, the casenotes stated "This patient will not be able to live alone again...". Four months later she suffered a stroke. Just over four years later, the notes observed "not needing medical care in hospital, but at risk". Mrs. Manfield seemed highly dependent on the nursing staff for help with all basic activities of life. She neither talked nor moved around on her own, and was probably not capable of forming or sustaining a meaningful social relationship with anyone. The patient's diagnosis as recorded in the nursing Kardex was "Myxoedema, pernicious anaemia: long stay" - no mention of senile dementia.

Mrs. Manfield's days were all much the same. She would be got up between 9.30 and 10.30, after having breakfast in bed. She would be put on the commode at the bedside, then washed and dressed. Twice a week an enema round preceded washing and dressing and Mrs. Manfield was included in this. When dressed, she would be taken (generally in a wheel chair) to the largest of the ward's three day rooms. All the incontinent patients tended to be located here, as the room was easy to clean, having no carpet. At lunchtime, she would be moved to sit at the table with several other patients in the dining area, at the other end of the large day room. She was able to feed herself. After lunch she would be taken to the bathroom and put on the commode, then returned to her armchair for the rest of the afternoon. For the evening meal, at around 5 p.m. she would again be moved to the table, usually in a wheelchair, sometimes walking between two nurses. Often she was back in bed by 6.30. Most of the patient's interactions were with nurses and centred around the purely functional. It was usually impossible to make any judgments about what the patient felt about her experiences in the ward.

The routines as applied to Mrs. Manfield, and the nature of inhumane treatment and distress are in contrast with the experiences of Mrs. Brayfield, who was the least alone of the study patients .

TABLE 5.1: SHIPTON WARD STRATEGIC PATIENTS*

<hr/>		
1.	<u>Mrs. Emily Manfield</u>	Most alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) -5</u>
	1	Very distressed by (routine) administration of an enema
	1	Morning wash given in undignified and superficial way
	1	Toiletted (on commode) in public
	1	Dressed while sitting on commode; no attention to cleanliness when patient had finished
	1	Became very upset when moved from dining room to bedside in a wheel chair
		<u>Secondary inhumanity (SI) - 7</u>
	6	Restless, shouting, agitated: ignored by staff
	1	Restless and agitated while in bed, throwing the bedclothes off and lying naked: ignored by staff
		<u>Total = 12</u> observations
2.	<u>Mrs. Eva Brayfield</u>	Least alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 1</u>
	1	Dressed while sitting on commode immediately after having been given an enema
		<u>Secondary inhumanity (SI) - 3</u>
	2	Made to share a table with a patient she disliked
	1	Complained she could not enjoy her meals in company with patients having revolting table manners
		<u>Total = 4</u> observations
3.	<u>Mrs. Florence Butcher</u>	Median
	<u>No. occasions</u>	<u>Primary inhumanity (PI) -2</u>
	1	Strongly disliked the (hospital) dress she had been given to wear
	1	Nurse removed patients sweetening tablets: considered patient put too many in her tea!

*See Appendix G for frequencies of inhumane treatment of strategic patients of all eight study wards.

TABLE 5.1 (Continued)

<u>3. Mrs. Florence Butcher</u>		<u>Secondary inhumanity (SI) 5</u>
<u>No. occasions</u>		
2	Made to share a table with a patient she dis- liked	
1	Upset by another patient's bad language	
1	Upset and angry about the prospect of moving to residential care: ignored by staff	
1	Upset and angry: ignored by staff	
<u>Total</u> = 7		observations

Mrs. Eva Brayfield. She suffered four instances of observed inhumane treatment out of a total of 50 observations. (This patient was discharged during my fieldwork). Mrs. Brayfield's experience of hospital contrasted with that of Mrs. Manfield. She had been admitted six days before I began fieldwork, and discharged just under two weeks later. She was 82 years old, and had been living in a warden-controlled flat. Although she had suffered from diabetes for many years, and was visiting the Eye Hospital as a result of bilateral cataracts, Mrs. Brayfield was basically a fit and active person. She had complained of feeling rather unwell for around six months, and, two weeks prior to admission had felt generally pretty poorly and had taken to her bed. In the medical notes, a review of her current symptoms led to a diagnosis of uncontrolled diabetes, atrial fibrillation and query urinary tract infection. Two days post admission, she was diagnosed as suffering from a chest infection. She did not become seriously ill as a result of this, and Mrs. Brayfield's stay in hospital featured steady improvement in her condition, and much active treatment. She had numerous diagnostic (e.g. ECG) and monitoring (e.g. blood sugar) tests during her stay, more frequent encounters with doctors than was usual for many of the other patients, regular visits to the physiotherapy department to help get her back on her feet again and other activities like visiting the

hairdresser. She was able to take care of many of her own physical needs, though her poor eyesight and the highly confusing layout of the ward sometimes meant she had to ask for help and guidance to get to the toilet and to wait on the nurses' convenience for the help she needed in getting up and going to bed. She was pretty positive about her experience of hospital. Sometimes she remarked that she found her days hectic and tiring, but said also that everything was doing her good, and she felt her condition improving dramatically all the time. This observed improvement, together with Mrs. Brayfield's endless store of risqué stories and jokes, made her a popular patient. Her only son, who visited daily, was also well liked. So popular was Mrs. Brayfield that the hospital's engineer and several of the porters would make excuses to visit the ward in order to call on Mrs. Brayfield and hear more of her stories.

Mrs. Brayfield's daily routine was more complicated and varied than Mrs. Manfield's, since the approach to her care from all the hospital staff who came in contact with her (or deliberately sought her out) was a personal one. Mrs. Brayfield's problems and her response to treatment fitted very nicely with the staff's apparent perception of her as an ill person who could quickly be restored to independence and discharged home, and Mrs. Brayfield and the staff appeared to share similar goals.

Mrs. Florence Butcher. She was the median patient (alone for 64% observations). Of 97 observations, seven featured inhumane treatment.

Mrs. Butcher was 89 years old, and had been living with an unmarried son prior to her admission, about a year before my three-week period of fieldwork began. She had been attending the day hospital for some time before that, and no particularly dramatic changes in her circumstances apparently precipitated her admission. The medical notes

described her as having no specific complaint except that she was forgetful and had painful knees. She was a known diabetic. Otherwise, her diagnosis was osteoarthritis of the knees, and 'social problem'. The nursing Kardex observed that her son did not want to have her home. The social worker reported that Mrs. Butcher had first been admitted because of her son's hospitalisation. According to various interested parties, Mrs. Butcher had been something of a tartar towards her family of eight children, and the hospitalisation of the son with whom she lived had provided the family with an outlet. Taking into account also what Mrs. Butcher herself said (I didn't meet the family) it seemed family relationships were very complex, and the process by which Mrs. Butcher's application for Part III accommodation had come about remained rather unclear to me: the application had been made about seven months before the fieldwork began.

In common with Mrs. Manfield, Mrs. Butcher's days were all much the same, although the repertoire of routines was wider and there was the occasional complete departure from routine, e.g. a day spent at a prospective old people's home. Mrs. Butcher seemed quite lucid most of the time. She was able to get around with minimal help, but relied on a zimmer frame. She was able to take care of most of her own basic physical needs, again, with minimal help. Thus she exercised relative autonomy in the ward, and - except at meal times - was able to choose which day room to sit in, go to the toilet when she wanted, and go to bed when it suited her. She was not a popular patient: she was quite grumpy most of the time, with staff and patients alike. Since she was a fairly quiet sort of person, it was not too difficult to ignore her grumpiness most of the time except, for example, when she quietly announced that unless she was given a nicer dress to wear, she would take the scissors and cut her current one to ribbons.

Resumé: The three strategic patients

In both quantity and nature, observed instances of inhumane treatment of Mrs. Brayfield and Mrs. Butcher were relatively less significant than much of what was observed at Bramlington, for instance. Mrs. Manfield suffered rather more: evidence that she might be distressed was ignored on a number of occasions, and she was not afforded appropriate privacy when personal care was carried out by the nurses. In particular, her distress when given an enema must be noted. It was routine practice on the ward to do 'enema rounds' twice a week, for virtually all the patients. Although overt expressions of distress were made by a minority of patients, it can be suggested that the very existence of such a routine is of itself inhumane. The persistence of this routine in the context of what was otherwise a milieu featuring much evidence of personal care for patients, e.g. the case of Mrs. Brayfield, seems anomalous and hard to account for.

Further data on practices at Shipton derive from interviews with the ward sister and two consultants, and from considering the extent to which their observed behaviour accords with their accounts of ward work. Data on staffing levels and workload will complete the Shipton case study.

Ward sister's interview

First, her perceptions of the ward's patients and nursing care requirements. She stressed the diversity of patients on the ward. They are admitted following domiciliary visits by consultants, from Casualty at District Hospital, as GP emergencies, and on holiday or rotating admission schemes. Patients have a wide range of usually multiple diagnoses, and many are confused. The only category of patient not found on the ward is that of rehabilitation following fractured femur: another ward in the hospital specialises in the care of such patients. Some patients are discharged, some die, and many stay for a long time. Most of the nursing work is basic, but

the aim is always to keep patients motivated to do as much as possible for themselves. None of the kinds of patients usually found on the ward presents particular nursing care problems. It is usually possible to predict how things will turn out for individual patients - often the nursing staff are much better at this than the consultants. She feels the consultants recognise this, thus allowing her some influence over key decisions, although sometimes it is a battle to get them to pay attention to the nursing perspective. She sees geriatric nursing as a specialty, the most important features of which derive from patients' multiple diagnoses and their social circumstances, which cannot be divorced from presenting illness and may often be more important, thus necessitating considerable energies devoted to sorting out social networks - e.g. prior to a patient's discharge. As geriatric nurses, sister and her staff become involved with both remedial therapists and therapy. The different staff are constantly in contact, and it is the nurses who do much of the physiotherapy - e.g. walking practice - on the ward. This is appropriate, because the nurses can then learn about and adopt consistent practices with individual patients. Efforts at rehabilitation are not likely to be successful if one of the nurses uses a wheel chair with a patient who could perfectly well walk: in no time, the patient will be trying to get all the others to use a chair.

Staffing. Sister feels that current staffing levels are adequate.

Besides herself, the ward's staff consists of two senior enrolled nurses, one of whom is full-time; one full-time enrolled nurse; eleven part-time auxiliaries and two full-time auxiliaries. There are also two 'ring-in' staff nurses (who are not on the regular pay rolls, but work those hours that they choose when the ward actually needs them).

The ward layout. The subdivision of the ward into small units may in some ways be nicer for the patients, but within each four-bedded unit it is almost impossible to afford individuals any privacy, due to lack of space. Also, patients get lost - the ward layout is confusing - and it is hard for the nurses to keep the whole ward under observation.

Facilities and resources are otherwise good, except that a relative shortage of occupational therapists and physiotherapists at present means that great selectivity is applied in deciding which patients would most benefit from sessions in the occupational therapy and physiotherapy departments.

Sister's objectives. For patients, these are: rehabilitation and improvement in the quality of their lives. Diversional activities must be provided. She aims to offer the majority of patients as much stimulation as possible, but also to enable people to die gracefully and with dignity. For staff, sister aims to nurture a happy, congenial work atmosphere, which is vital because the work is so hard. For herself, she finds satisfaction in seeing patients discharged, but also in helping patients to die with dignity.

Organising the work. Sister regards herself as having considerable autonomy when it comes to organising ward work, although some things are outside her control, such as meal times and doctors' policy on bed use. She tries to influence this, and succeeds unless the rest of the hospital system is under too much pressure. For example she tries to resist admission of too many stroke patients, because this increases the ward's workload too much. On the whole, she plans work on a daily basis, as it is not always possible to predict workload and staffing levels. Work planning features routines: "We don't like to think there's a routine, but there is - there's a routine patients fit in to". A typical day is as follows.

If coming on duty at 7.30 a.m., sister takes a report from the night staff, and sees any particularly poorly patients. The nurses know what is to be done, the enrolled nurses get on with the job. Breakfasts arrive about 7.50 a.m., most of the patients have breakfast in bed. After that, the nurses are allocated to work on one side of the ward or the other, and patients are given what help they need with getting up. Sister dips in and out of the work - there are enough staff for her to be able to do this, and in any case she sees herself as a co-ordinator between the various staff disciplines, and ward manager. Specific one-off tasks are allocated to individual nurses, but otherwise the nurses know what to do. After getting up, some patients may go off to therapy, and once a week there is a morning ward round, where formal interdisciplinary liaison takes place. The second consultant does a round one afternoon a week, otherwise, liaison happens informally: over meals, in corridors etc. The patients' lunch is at about 12, after which there is a toilet round - the only one of the day, otherwise, toileting is on demand. There is generally a report session in the afternoon, which reviews all the patients and the ward work as a whole. Patients may go off for therapy again, and diversional activities may be arranged in the ward. Also people may visit between 2 p.m. and 8 p.m. The evening meal is at about 5 p.m., after which more than half the patients go back to bed. The rest go to bed later, perhaps watching TV during the evening.

If there are no other trained staff on duty, sister participates in ward work to a greater extent. At weekends, there are intentionally fewer staff on duty than during the week: thus if on duty, sister becomes 'a pair of hands'.

In judging the ward's performance, sister feels that she is able to achieve her objectives most of the time. Unpredictable events can sometimes make for difficulties - e.g. an unexpected death - and so-called 'Sunday visitors' can make tremendous trouble. These are relatives who visit infrequently, and complain a great deal. Probably they have their own problems, including guilt feelings over the very fact of their relative being in hospital, but they can make life pretty unpleasant and difficult sometimes. On the whole, the quality of care is good, though there is some shortfall on the diversional therapy side. She thinks the ward is efficient: "I'm a great one for lists" - she likes to identify everything that needs to be done, in order that important things don't get missed.

Consultants' Interviews

Two consultants shared the beds on this ward. One of them was responsible for all the beds on the study ward at Heathlands, and shared the beds with two other consultants on District ward. The other consultant was one of the three having beds on District ward. Both consultants were interviewed during the fieldwork at District, which was the second ward studied. Since the substance of both discussions was relevant to understanding their part in all and any of the wards in which they worked, I did not re-interview them when I met them again later on. I did, however, have many informal conversations with both of them, some material from which will be incorporated in the following accounts.

1. General philosophy of geriatric care. Dr. Livingstone had taken over the running of the hospital geriatric service for the whole of the health district four years before I began the research. In seeking to

improve the service provided to the elderly people of the catchment area, numerous changes were introduced with the aim of developing the service from one providing exclusively long-term care - featuring a long waiting list, therapeutic nihilism and problems with staffing levels - to one able to offer tailor-made care to people with the whole gamut of medical problems, from acute illness through to chronic, long-term limiting illness. Thus as beds became freed, the admissions policy was changed, and emergency admissions began to feature, along with the introduction of active treatment and rehabilitation - perhaps a tendency to over-treat in the beginning, but individual assessment and treatment planning now means that the plan may feature positive decisions not to treat some patients. Another aim is to have a mix of patients in all the wards with which he is concerned (a minority of wards have developed specialist functions, e.g. rehabilitation of fractured femur patients) so that all have their share of acute and longer term work which Dr. Livingstone believes is beneficial for both patients and staff.

2. Who comes into the ward and how. Direct emergency admissions from casualty at District Hospital, GP emergencies, patients seen on domiciliary visits or in outpatients, transfers from other wards - speedily from surgical wards (since for the patient needing rehabilitation the experience on such wards may be damaging) and not for three months from medical wards (which ought to be doing their own rehabilitation work). Most patients are at least 75 years old: if younger, they are probably referred elsewhere first. Too many patients have psychiatric problems, but the local psychogeriatric service is woefully inadequate, thus the geriatric service has to cope as best it can.

3. The consultant's role in patient care. Dr. Livingstone sees himself as leader of a multi-disciplinary team, the purpose of which is not only to plan and implement patient care, but also to develop, through case conferences and shared working, the right attitudes and practices among the team workers. At Shipton, Dr. Livingstone does a round each week. He does not see every patient: typically, he aims to see any newly admitted patients, any whose condition has changed markedly, those whom sister asks him to see for whatever reason. and, in rotation, some of the longer stay patients, planned so that each is seen about once a month. After the ward round, when he is usually accompanied by the ward sister, and sometimes the physiotherapist and/or occupational therapist, the patients are discussed and reviewed in the office, and any prospective admissions are also considered by the group. He feels clear that it is appropriate for him to take the leading role in the care of acutely ill and rehabilitation patients, as correct diagnosis and meticulous medical care is a prerequisite to appropriate rehabilitation work. But with the long-stay patients, he is not so sure. He feels that hospital is the wrong place for many of the long-stay patients, who are often not in need of medical care, and, in some cases, not nursing care either. However, given that, for whatever reasons, some long-stay patients are a fact of life, then the nurses are the most appropriate people to take responsibility for their care. But since this happens in a medical milieu, whether one likes it or not, it is vital for consultants to take an active interest, in some way, in long-term care.

4. Strengths and problems of patient care in the ward. As turnover has increased, the work pressures on staff have increased, and the nature of nursing work has changed. This has caused some problems, and there has

been a long and sometimes painful phase of realignment among nurses to the changed aims and patterns of work - though mostly these problems are now resolved. But no NHS hospitals, including Shipton, are much good at providing residential-type care: e.g. it is appalling that patients cannot have their own clothes.

A second consultant

Dr. Burton, having joined Dr. Livingstone some years after he began his reorganisation of the hospital geriatric service, believes he holds a very similar philosophy about geriatric care. However, he sees himself as a general physician first and foremost, and believes that geriatrics as a specialty should die the death over the next few years. It has served its purpose in raising medical consciousness, and explicating the special features of presentation and management of medical conditions in the elderly, and, as such, should be reintegrated with general medicine. Given the continuing low status and understaffing of geriatrics, such a development would provide better chances for establishing uniformly high and equitable standards of hospital care for elderly patients. Although the goals of treatment may be different for some geriatric patients - e.g. care is a legitimate activity in the absence of any thought of cure - on the whole the general aim of a geriatric service, as any other specialty, must be about achieving rapid discharge rates. Only then can resources be deployed to the greater good of the elderly population in the catchment area. He sees the patient as a member of the treatment team. He feels the geriatric arena suffers from over-medicalisation. If the orientation is to be towards helping meet the needs of elderly people, then for instance it ought to be possible to supply appropriate footwear for all who need it, on the NHS.

1. Who comes into the ward and how. Dr. Burton's account did not differ from Dr. Livingstone's.
2. Consultant's role in patient care. Again, Dr. Burton's account of his style of working was similar to Dr. Livingstone's. He was very explicit about saying that he was trying to move away from the traditional role of the doctor as final arbiter in deciding what is to happen to patients. In some situations, for example, the nursing auxiliary may be the person with the most pertinent opinions about how to solve a particular problem. Dr. Burton tries to raise various alternative strategies when planning/managing patients' care, and to get members of the staff team to contribute more to decision making. Sometimes he is faced by consternation - traditional expectations about the behaviour of doctors in their positions of supremacy die hard.
3. Strengths and problems of patient care in the ward. Ward facilities are bad for patients and staff - though Shipton is much better than some of the units, particularly District geriatric unit, with its former workhouse accommodation. More remedial therapists are needed. The health district's inadequate psychogeriatric service adversely affects the mix of patients at ward level.

Key Actors' Work Practices: Ward Sister and Consultants

Ward sister. The daily routine was much as she had described, though the availability of diversional activities was even more limited than her account had suggested. However, it was the summer time, and quite a number of the patients enjoyed sitting outside the ward in the sun, overlooking a pleasant view of adjacent farmland. She did indeed work as she had said: spending quite a lot of time on co-ordinating the work of the various people involved with the patients and planning discharges..

She always participated to some extent in work with patients as well. She was a great one for lists and work books which some of the staff disliked intensely. One feature of her work about which all the staff felt very strongly was enema rounds: considered horrific by most of them, and an unnecessary and unpleasant chore for both staff and patients. Despite regular arguments, the routine persisted. This seemed anomalous, given that the ward sister was in other ways a concerned and apparently highly competent professional worker, who knew all her patients and their preferences and needs very well, and expected her staff to be likewise. Apart from this routine, patients were afforded considerable individually-oriented care and treatment. One of the study patients died towards the end of my three week research period, and it seemed to me that in this case sister's general approach offered support to the family and helped the patient to die a 'good' death.

Yet despite evidence of patient-centred care, there was also evidence of patients suffering. Mrs. Manfield's treatment did not always match basic standards of human dignity. Her signs of distress were largely ignored: perhaps because staff were at a loss as to what positive steps they could take to comfort Mrs. Manfield.

The Consultants. What I observed of Dr. Livingstone's behaviour on the ward fitted exactly with his own account of it. This was also true of Dr. Burton. But Dr. Burton's account of his attempts to democratise decision making seemed rather different from what I observed. Patients' active involvement in decision making was limited - though in the case of Mrs. Brayfield (above) her wishes about discharge and its timing were in fact sought and taken into consideration (this issue will be taken up in Chapter 7, p.267 in connection with teamwork more generally). Sometimes Dr. Burton would make unilateral announcements, with which

everyone else disagreed. Staff were sometimes able to cope with this because they knew Dr. Burton had an erratic memory, and was in any case liable to change his mind. Thus what the nurses regarded as, for example, injudicious decisions to discharge patients would be ignored, often without any comeback. Dr. Burton had himself observed that there were times when he felt unsure about his own role and, although he believed shared decision making was to the advantage of patients, he said he found it very difficult to take on board the accompanying reduction in his own control over events, with the consequent uncertainty this created - particularly in complex cases, where appropriate strategies were far from self-evident.

Resumé: Patients' Experiences and Ward Work Processes

Taken together, the relatively low level of observed inhumane treatment, the sister's and consultants' verbal accounts of aims and patterns of work and their observed behaviour in practice, all suggest that conscious work strategies were reasonably effective when it came to avoiding treating patients inhumanely. The enema rounds remain as a one-off example of an anomalous and inhumane practice. As in the preceding chapter, it is necessary to consider how staffing levels and patient-nurse dependency might relate to patients' experiences.

Staffing Levels and Patient-Nurse Dependency

Numbers and grades of staff have been noted in the sister's interview. Staff numbers actually on duty during fieldwork were as follows.

FIGURE 5.1: SHIPTON STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	6.7	10	4
Afternoons	7.1	10	3
Evenings	4.3	7	3

In interview, the ward sister said she felt staffing levels were generally adequate. She also said that eight or nine nurses were needed in the mornings, four or five in the afternoons and evenings. Four nurses were judged to be enough at all times at the weekends, when there were fewer interruptions and no calls on the nurses' time as a result of non-nursing work with patients. Most of the time, sister's expectations were met.

The number of patients on this 34-bedded ward varied between 30 and 32. Usually all but one or two patients were rated as care group 2 - requiring considerable help from nurses with basic care. The exception(s) were rated as care group 1: needing minimal help. (See Appendix D for details of the Barr Dependency Checklist). Shipton was, almost all the time, better off than other wards in terms of the numbers of staff available to care for the ward's patients, and in that no patients were ever defined as coming into the heaviest workload category. (See Appendix H for staffing levels of all eight wards). The ward layout at Shipton perhaps of itself warranted more generous staffing levels, but even so, the data raises the question of whether Shipton's better outcome regarding quantity and quality of inhumanity could be accounted for merely by better staffing levels.

The hypothesis that the better staffing levels are significant cannot be refuted, but it is worth noting that there was no evidence to suggest that quantity or quality of inhumanity differed when staff numbers were relatively low, in the evenings and at weekends.

Routinised care, with some efforts to take account of individuality (with the exception of the enema rounds), prevailed at Shipton. As with Bramlington and Cranford, Miller and Gwynne's Warehousing model of residential care is strongly in evidence. However, the nature of the majority of routines, and the balance between routinised and personal care is such that observed inhumanity was relatively infrequent, and few of the fundamental insults to dignity which were observed at Bramlington so often, were to be seen at all at Shipton. Thus the prevailing style of patient care at Shipton can be described as 'personal warehousing'.

Eastwood Ward

Eastwood was a male ward with 28 beds arranged in bays and single sideways. It was in a purpose-built geriatric block of a general hospital. Some patients were short-term relief admissions, the ward was said to accept acute admissions, but the majority of the patients were long-stay.

The strategic patients

Mr. John Ewing. This patient was the most alone of the study patients. Table 5.2 shows that four observations featured inhumane treatment. Mr. Ewing had been in hospital for two years

TABLE 5.2: EASTWOOD WARD STRATEGIC PATIENTS*

1.	<u>Mr. John Ewing</u>	Most alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 3</u>
	1	Consultant treated him like a child
	1	Charge nurse belittled symptoms of which patient complained
	1	Doctor belittled symptoms of which patient complained
		<u>Tertiary inhumanity (TI) - 1</u>
	1	Nurse belittled patient's symptoms during report session
	<u>Total</u> = 4 observations	
2.	<u>Mr. Horace Birt</u>	Least alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 6</u>
	3	Patient failed to get satisfactory answers when questioning staff
	2	Consultant ignored patient
	1	Consultant appeared not to know why he had admitted patient
		<u>Secondary inhumanity (SI) - 9</u>
	8	Looked depressed and/or expressed worry about being in hospital and about hospitals and doctors in general; and received no reassurance
	1	Felt unwell, but was ignored
		<u>Tertiary inhumanity (TI) - 2</u>
	2	Neither doctors nor nurses understood why patient had been admitted
	<u>Total</u> = 17 observations	
3.	<u>Mr. Jack Satchwell</u>	Median
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 9</u>
	4	Clothes inappropriate or dischevelled
	1	Treated like a baby by an occupational therapy student
	1	Consultant and other staff discussed patient in his presence while ignoring him
	1	Patient not informed of visit arranged to his wife
	1	Patient offered food while lying prone, and unable to lift himself
	1	Patient disliked food
		Continued ...

TABLE 5.2: (Continued)

Mr. Jack Satchwell (Continued)

<u>No. occasions</u>	<u>Secondary inhumanity (SI) - 2</u>
1	Distressed over wife's hospitalisation and the lack of help to arrange for him to visit her: his distress was ignored
1	<u>Very</u> distressed: wife died before he had been taken to visit her. His distress was ignored
	<u>Tertiary inhumanity (TI) - 4</u>
3	Various abortive arrangements made to take patient to visit his wife: patient not informed nor involved
1	Staff aimed to discharge patient to Part III accommodation without his knowledge. They agreed to withhold his tobacco if he did not co-operate with their rehabilitation programme.
<u>Total</u> = 15 observations.	

*See Appendix G for frequencies of inhumane treatment of strategic patients of all eight study wards.

following a stroke which had left him greatly disabled and doubly incontinent. He was also suffering from Parkinson's disease. He was 77 years old, and had been living alone. He had no children. His other medical problems were polycythemia, aortic sclerosis, prostatism and diverticulitis. During his hospital stay he had suffered a serious bout of chest infection, also pressure sores on his buttocks. Four months before my three-week period of research, he was defined as "for long-term care" in the medical notes. Mr. Ewing could do little for himself and, though there was no

mention of impaired cognitive function in any written records, he seemed very withdrawn, and never really engaged in any conversation or social interaction, to the extent that I wondered whether he was capable of doing so. Mr. Ewing's days seemed all much the same. After breakfast in bed, he would be taken to the toilet on a commode chair, after which he was given a wash at the bedside and dressed, usually with the curtains closed around him. Then he would be taken to the day room in a geriatric chair. He would sit there, doing nothing other than drinking his cups of tea and coffee, and eating his lunch, until after the evening meal, when he would be put back to bed. He seldom interacted with anyone apart from nurses and the barber and, once a week, the doctors on the ward round. It was difficult to judge how he felt about his experience in hospital, and from three of the observed incidents of inhumanity, which all concerned the patient's complaint of having a painful knee, it seemed that there was complete absence of any evidence of staff attempting to provide any sort of personalised care for this patient. However, although Mr. Ewing's observed experiences featured nothing particularly positive, at least there was a relative absence of inhumanity.

Mr. Horace Birt. This patient was the least alone of the study patients.

As Table 5.2 shows, 17 observations featured inhumane treatment. His ward experience was very different from Mr. Ewing's. He was admitted to the ward during my research period, and what I observed of his ward career featured

considerable confusion: among staff, regarding the reasons for his admission and for the patient himself, whose efforts to discover what was going on and when he would be discharged were constantly thwarted. He quickly began to suspect a conspiracy between staff and his daughter, who, he said, perhaps wanted to "get rid" of him. I didn't meet his daughter, and the staff account was that there was no question but that he would return home.

Mr. Birt was 84 years old. He had been in hospital earlier in the year for two weeks to give his daughter a holiday. At that time there was some question as to whether he was suffering from pernicious anaemia and osteomalacia, and the consultant had told his GP that he would be admitted in due course for tests. And hence his admission, from the outpatient clinic, during my research. Mr. Birt said he was sometimes short of breath, and had been falling at home but otherwise he felt he was in good health. Neither senior house officer and registrar, nor the nurses, seemed to have any idea why the patient was in hospital. Two days after admission, during the ward round, the consultant also seemed to have to stop and think about this. Assessment of the patient also seemed puzzling. The medical notes said he was able to walk only with a zimmer frame, but he never used any walking aids in the ward. He was also described as confused: he seemed quite the contrary to me.

Mr. Birt apparently needed no help with the activities of daily life. He fitted himself into the daily routine of the ward, getting up and dressing after breakfast, and spending the day partly in the day room - sometimes talking with other patients - and partly sitting at his bedside. He was able to decide for himself when he would go to bed at night.

A majority of the observed inhumane treatment experienced by Mr. Birt had to do with the staff's vagueness over the patient and reasons for his hospitalisation, and Mr. Birt's failure to get any satisfactory account from anyone (see Table 5.2). There was little semblance of any organised initiative on the part of any of the staff to embark on personal care or treatment of this patient.

Mr. Jack Satchwell. He was the median study patient in terms of the proportion of observations in which he was alone. Fifteen

observations featured inhumane treatment. Mr. Satchwell was 89 years old, and had been admitted to the ward about three weeks before the start of my three-week period of research. The immediate reason was that his wife had been admitted to a surgical ward at the same hospital, and Mr. Satchwell was unable to look after himself at home. On admission, the medical examination had culminated in diagnoses of (1) osteoarthritis in the knees; (2) obesity; (3) incontinence of urine; (4) chronic bronchitis and (5) hypertension. Mr. Satchwell smoked at least half an ounce of pipe tobacco daily, walked reluctantly and unsteadily with a zimmer frame and seemed to need quite a lot of help with washing and dressing. He appeared mentally alert to me. Rehabilitation had been prescribed, and the patient was to be encouraged to do as much as possible for himself. The staff's aim was to discharge the patient - he wanted this too - but, as fieldwork proceeded, it emerged that the staff's vision of discharge was Part III accommodation, which Mr. Satchwell himself did not know. The withholding of tobacco as a negative inducement to greater efforts at self-help was agreed among the staff towards the end of the research period.

The inhumane treatment experienced by Mr. Satchwell is summarised in Table 5.2. It included lack of attention to basic dignity and courtesy due to adult human beings, and muddles over abortive arrangements to enable Mr. Satchwell to be taken across the hospital site to visit his wife. Apparently she had at first not wished to see him, but later changed her mind. The unsuccessful attempts to organise a visit spanned a number of days, nobody - except the patient himself - seemed to accord the problem much priority or urgency. Then Mrs. Satchwell died, taking everyone on Mr. Satchwell's ward quite by surprise. Mr. Satchwell thereafter became very distressed. A few days later, he spoke as though he was quite unaware that his wife had died. Ward staff made no constructive efforts to respond to Mr. Satchwell's distress.

Resumé: The three strategic patients

Mr. Ewing, who was the least 'engaged' of any of the study patients with the ward's routine, suffered the least of the strategic patients. This parallels the findings at Cranford and Bramlington, but differs from Shipton. Both Mr. Birt and Mr. Satchwell experienced considerable inhumane treatment, quantitatively and qualitatively. Although each man experienced very different kinds of inhumanity, there is a common theme: staff seemed quite vague and confused about the nature of patients' individual problems, made no great efforts to clarify things and attached scant priority to taking action which would be visible to the patients in terms of offering something positive and definite towards the solution of their own problems. A depressing picture indeed. I will now turn to data from interviews with the charge nurse and the consultant.

Charge Nurse's Interview

First, his perceptions of the ward's patients and the nursing care requirements. One bed is kept empty (out of 28) for emergency use in case of need by the day hospital. Two are for floating admissions - people who come in for two weeks on a regular basis - and one for holiday admissions, a once-off fortnight during the summer. Other admissions come from internal transfers and domiciliary visits. There are very few GP emergency admissions and none from casualty. The beds are usually full. There is a waiting list. He thinks the discharge rate is slowing up - most patients die. The main diagnoses are stroke, Parkinson's disease and dementia, and there is little active rehabilitation. Most of the nursing work is very basic. There is no point in trying to predict how things will turn out for individual patients, nor in trying to plan work: although patients' problems can be identified, there are never the resources needed to be able to do anything about them. To plan work under these circumstances would serve merely to raise false expectations regarding what can be provided. He sees geriatric nursing as a specialty, for which experience in mental nursing (his own background) is the most relevant. Medical labels are neither here nor there: at least 50% of problems are social, precipitated by a medical condition. Functional understanding is more useful than medical diagnosis. The charge nurse said the nurses never get involved in working with therapists because there is no time. But he believes that, apart from assessments, the nurses would be the best people to do the day-to-day work that therapists do at present. It is non-specialist work, after all.

Staffing. There are two full-time enrolled nurses, one who works four and a half days a week, and one full-time enrolled nurse here for the vacation only. There is usually one student and one pupil nurse, also three full-time and three part-time auxiliaries, and, just for the vacation, an intending medical student working as a full-time nursing auxiliary. There are not enough staff, and he cannot say how many would be enough. The ward layout and facilities are fine, except that doors are a bit narrow in the toilets, and the nurses' station is in the wrong location for a geriatric ward, where most patients are up and in the day room. Occupational therapists and physiotherapists make very little input. Physiotherapists walk three or four patients and that is about it.

Objectives. The charge nurse says that, for patients, he wants to increase the emphasis on rehabilitation, but that until very recently he has had "a bad bunch of staff". For staff, he wants to increase the emphasis on training, and for himself, "to see my way through the day without going bananas".

Organising the work. The charge nurse's account was as follows. At 7.45 the breakfasts are served to the patients, in bed. All staff are involved. Then the patients are got up. The routine is so basic that everyone knows what to do - unfortunately. The auxiliaries serve coffee about 10.30. Students and enrolled nurses do temperatures, pulses and respiration (TPR's) and any dressings, also the medicines. At 12.00, lunch is served, and all staff help. Then the incontinent patients are toiletted. Medicines are done again, and during the afternoon auxiliaries do baths, teas, preparing beds for the

night, cleaning lockers, weighing patients (monthly). The trained staff do the Kardex, finish any dressings etc. and help with baths. In the evenings, all staff help with everything. Three patients - who can't feed themselves - are put to bed around 4.30. Tea is served at 5-ish, after which the rest of the patients, except one or two self-care patients, go to bed. Nobody objects. Patients aren't forced to go to bed, but they're not asked if they want to. Very few patients actually watch TV, though it's on most of the time. They prefer TV to radio. On Thursday mornings there are ward rounds. The senior house officer comes to the ward daily. There are no case conferences - there ought to be, for staff training purposes: case conferences wouldn't help the patients much. He organises the beds in a deliberate way. The top bay is for chronic patients, who get little attention from the doctors. The next bay - opposite the nurses' station - is for physically ill patients, who get some attention from the doctors. The other two bays also get little attention - patients here are chronics again, and any self-care patients, and perhaps holiday admissions.

Efficiency and quality of care. The charge nurse doesn't believe the ward matches up to what he thinks its objectives ought to be. There are too few nursing staff, also he finds it difficult to keep in close touch with what's going on because there are so many interruptions. Also he is often acting up for the Nursing Officer, which means that he frequently has to leave the ward. Despite his rather gloomy view of the ward, the charge nurse felt he had considerable autonomy to run the ward his way provided he fitted in with other institutional constraints. He regarded himself as being responsible to the Nursing Officer.

Consultant's Interview

One consultant, Dr. Stanley, controlled all the ward's beds. An oft-used phrase in our discussion was "It's all a question of balance" ... Another such phrase: "It's like running a regiment or a ship ..." The idea of geriatrics as a specialty is ridiculous: there's no special expertise about it, it only exists by default. The elderly are an unpopular commodity: no-one likes them, even the staff. His job is to strike a reasonable balance between community and hospital demands. Broadly there are three types of patients: acutely ill, who definitely need hospital care, the intermediate, who can just about manage, but might be helped by a spell in hospital, and the less acute: people with chronic, limiting conditions. Too many geriatric units are obsessed about turnover, and therefore won't take any but acute admissions. He feels this is wrong: if you don't take the intermediates, somebody suffers, probably the relatives, and probably in silence. Therefore he tries to take admissions of all three types - this is part of the balancing act he refers to. Long-stay care and psychogeriatrics present problems. With long-stay patients, either you can spread them around all the wards, or concentrate them together. Having tried both, he feels the latter is the better way, as they tend to get neglected if they are located with mainly acute and rehabilitation patients. Also there are a few nurses who really enjoy working with long-stay patients, and are excellent at it. It is physically very difficult to manage psychogeriatric patients in the hospital, but as there is no psychogeriatric service, the hospital has quite a few of them. There is no real policy, ad hoc responses are made to ad hoc needs, and there are continuing attempts to get the psychiatrists to co-operate in looking at the

problem district-wide. In achieving the right balance and running the regiment, it is necessary for the doctor to know everybody very well, to become personally involved in a lot of administrative work, and to "stick his nose into everything" - it is only the consultants and senior registrar who are in a position to take the bird's eye view which is so essential to reviewing how the hospital is doing. He feels the hospital does pretty well: they are lucky in having a modern unit, and in having relatively good access to community support services. But they also have their problems. They really need three and three quarters consultants, instead of just two, to cover all the beds in the hospital. And there are shortages of nursing staff, occupational therapists, physiotherapists and speech therapists. These shortages affect decisions about which patients should be admitted.

(I didn't have a chance to ask Dr. Stanley anything very specific about the ward: neither his own part in patient care, nor views on the ward. He terminated the interview very quickly, and though I made two other dates to talk to him again, he did not keep the appointments).

Key Actors' Work Practices: Charge Nurse and Consultant

Charge Nurse. The daily routine was much as he had described, though there was sometimes a daily nursing report session which he didn't actually mention. The charge nurse hardly ever participated in the work, and was often away from the ward, as he had said. He didn't seem to know very much about the patients - not really surprising. Nor to care very much: he had come in to geriatric nursing because he felt it offered good possibilities for rapid promotion - he had his sights set on managerial work. He was extremely unpopular with

all the staff because he was seen as uncaring and, although a convincing talker, incompetent. The person on the ward who seemed to know most about the patients, and to whom nurses and relatives alike turned with their queries and worries, was the part-time ward clerk. She was expecting a baby, and there was much sadness among the staff that she would soon be leaving.

Consultant. Dr. Stanley came, as the charge nurse had said, to do one ward round a week. On round days, patients would remain seated at the bedside until the round was over. All patients would be seen, though for most this meant "Good morning, how are you" and quickly moving on. The senior registrar, senior house officer and senior nurse on duty always went on the round, and, during the fieldwork, the social worker joined the round to talk about specific patients: always including Mr. Satchwell, described above. Dr. Stanley's attention was clearly reserved for patients who were physically interesting and/or whose cases were very complex. He tended to talk down to patients - literally, in that they were always seated and he was always standing - and also socially. An illustration relating to Mr. Birt (above) can be given here (p.24 Eastwood fieldnotes).

"The ward round arrives - patient initiates: "I've only got bronchitis, I don't want to be here, what I want (for my holiday admission) is an old people's home with nice chairs to sit in, and a bit of quiet, not a hospital. You can send me out as soon as you like....". Dr. Stanley is reading casenotes, and totally ignores him. In the end he says 'BE QUIET' - and the patient is, briefly. Dr. Stanley doesn't seem to know why he's been admitted ... ah, for investigations. Tells Dr. A. (senior house officer) to do xylose tolerance and barium follow-through. Patient says he's in for a

holiday ... Dr. Stanley asks who he lives with - daughter, O.K. Doesn't ask patient anything else - it's as though the patient as a person just doesn't exist, he's just a bundle of medical problems. Patient keeps on asking when he's going home and why he's here, but gets no reply. He is still asking as Dr. Stanley walks off, ignoring him. The entourage follows".

Resumé: Patients' Experience and Ward Work Processes

Apart from Mr. Ewing, who fitted into the routine passively, and suffered relatively little in the way of inhumane treatment, there was considerable evidence of inhumanity in relation to the other two strategic patients. Although, of course, each was unique there was nothing to suggest that their experiences were exceptional. The charge nurse's account of work created a picture of straightforward basic services provided in an entirely routine fashion by a nursing staff that was continually under excessive pressure. He knew little about the patients - even saying that medical diagnoses were unimportant - nor about the work process, in any detail. His personal interests lay in promotion. The absence of concern with patients' wellbeing which came over in interview was also evident in the charge nurse's serendipitous involvement in and surveillance of ward work. My impression was indirectly supported by the views spontaneously expressed to me by all the ward's nursing staff, as well as the domestics and ward clerk. Dr. Stanley's involvement at ward level was largely focussed on medical problems which were 'active' at some level, including any non-medical issues which might have a direct bearing on the outcome for the patient - e.g. he became quite involved in deliberating the options available for the future of Mr. Satchwell after his wife had died. His behaviour with patients suggested,

however, that large numbers of them required very little of his attention, and, further, that what really interested him (besides medical questions) was not so much patients themselves, but the logistical challenges in managing patients' careers such that the whole hospital was running "like a good regiment" - undeniably an important concern for a consultant. The ward's routines could cope quite well with avoiding inhumanity for patients like Mr. Ewing, but were largely useless in responding to the particular needs and problems of Mr. Satchwell and Mr. Birt. And there was little evidence of prompt and effective initiative being taken by anyone in order to institute any kind of personalised care strategy expressly aimed towards resolving these patients' problems. True, some individual decisions were made - Mr. Birt's diagnostic tests were arranged, as was the rehabilitation programme for Mr. Satchwell. But neither was seen as satisfactory by the patient concerned. Mr. Birt still failed to find answers to the questions which worried him, and Mr. Satchwell's love of smoking was to be used as an inducement to participate in the planned attempts at re-mobilising him.

All this ceases to be surprising in a ward where there is apparently nobody in an officially authoritative position who has any explicit strategy for defining and managing work with patients in relation to patients' own perceptions of their needs and problems. The consultant was an absentee landlord who acknowledged that old people are an unpopular commodity. The charge nurse appeared to have abdicated from his responsibility towards patients, saying that efforts to improve things were pointless owing to shortage of staff; and in practice distancing himself from the work process. Who then is responsible for long-term care? At Eastwood it seemed that nobody was. This question will recur, and is reassessed in Chapter 8.

A very bleak picture of Eastwood emerges. There were, however, a few bright spots, which happened despite the ward routines and originated from particular individuals: e.g. humane treatment was regularly offered by two auxiliaries. (This will be discussed in Chapter 8).

Earlier, I noted that Dr. Stanley said the whole hospital suffered because there were dire shortages of nursing staff, and that the charge nurse also said, repeatedly, that there were so few nurses as to render inconceivable any thought about how work ought to be done. Unlike the sisters of the wards already described, the charge nurse wasn't able to say how many nurses he thought the ward needed - he said that you would have to find this out empirically, "by saturating the ward with nurses, and seeing what happened".

Staffing levels and patient-nurse dependency

Numbers and grades of staff have been noted in the charge nurse's interview. Staff numbers actually on duty during fieldwork were as follows.

FIGURE 5.2: EASTWOOD STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	4.2	6	3
Afternoons	5.4	8	4
Evenings	3.4	4	3

The number of patients on this 28-bedded ward varied between

25 and 27. Usually, all but one or two patients were rated as care group 2 - needing considerable help from nurses with their basic care. The exception(s) were either care group 1 (needing minimal help) or 3 - the most dependent category. (See Appendix D for details of the Barr dependency checklist). Looking at the figures for Shipton (see Summary Chart at Appendix H) Eastwood is worse off for staff - but there are always five fewer patients at Eastwood. Looking at Appendix H again, Eastwood has fewer staff relative to beds than does Cranford in the mornings but has roughly the same staffing levels, for fewer patients, in the afternoons and evenings. The staffing levels at Eastwood are about the same as at Bramlington - better in the afternoons - for a ward having about seven fewer patients.

Because the charge nurse wasn't able to say how many staff he thought the ward needed, we cannot consider the relationship between expectations and reality. But in looking at the situation in three other wards, the situation at Eastwood is not markedly deviant. Thus data from Eastwood does not altogether support the notion - put forward by the charge nurse - that low staffing levels and high workload can account for almost all deficiencies in humane treatment of patients. This is not to say that staffing levels and workload are not relevant at all, but, as earlier sections have shown, patients' experiences can be better understood in the context of ward sisters' and consultants' beliefs and work strategies, alongside the factors of wards' physical environments and staffing situation.

Routinised care and inhumane treatment were features of Eastwood. Miller and Gwynne's warehousing model of residential care once again comes to mind. Unlike the situation at Shipton, there was little evidence of

any intentions or practices of responding to patients as individuals with important and distinctive needs. Thus Eastwood can be described as a Minimal Warehousing ward. The staffing situation was doubtless a real problem. However, it was not the only problem, and the process through which the inhumanities arose only became visible when the behaviour and beliefs of key staff were examined.

Moorhouse Ward

Moorhouse ward had 29 beds, and was divided into two wings, one for men and one for women. The day room was located between the two wings. The ward was in a purpose-built geriatric unit, a short distance away from the catchment area's general hospital. There were some short-term admissions, and a minority of patients were for rehabilitation. Most of the patients were long-stay.

The strategic patients

The observed examples of inhumane treatment are summarised for the three strategic patients in Table 5.3.

Mr. Edwin Hutchinson was the most alone of the study patients.

I observed no inhumane treatment of this patient.

Mr. Hutchinson had been in hospital just over seven years, and he was 88 years old. He had been living alone, and was admitted on referral from his GP, having become very dependent on neighbours, also "confused and irrational". He was so agitated on admission that a psychiatrist had been called urgently. The assessment was inconclusive, and the treatment largactil. The following day Mr. Hutchinson was examined, but no diagnosis was recorded in the casenotes. Two weeks later he suffered a stroke. He was discharged two months later, but readmitted

TABLE 5.3: MOORHOUSE WARD STRATEGIC PATIENTS*

1.	<u>Mr. Edwin Hutchinson</u>	Most alone
	<u>No. occasions</u>	No inhumane treatment observed
2.	<u>Mrs. Alice Larkin</u>	Least alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 37</u>
	12	Complained of distress/discomfort as a direct result of staff treatment
	20	Complained of neglect by staff
	2	Disliked food/drink offered
	1	Offered preferred food, but never given it
	1	Reported she was told to wee in the bed at night rather than ask for commode
		<u>Secondary inhumanity (SI) - 12</u>
	12	Observations suggested patient in great pain, no action taken by nursing staff
		<u>Tertiary inhumanity (TI) - 7</u>
	2	Nurses said she moans too much
	3	Patient described as a problem
	1	Nurses bemoaned lack of sheepskins/ripple beds, but took no action
	1	Daughter expressed great worry, and inability to get satisfactory explanations from staff
		<u>Total = 56</u> observations
3.	<u>Mrs. Elsie Moroney</u>	Median
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 2</u>
	1	Patient had very smelly mouth
	1	Patient given coffee while seated in geriatric chair which was tipped back, thus it was difficult to drink without spilling, and impossible to put the cup down
		<u>Total = 2</u> observations

*See Appendix G for frequencies of inhumane treatment of strategic patients of all eight study wards.

the same day having collapsed while out shopping. This time he was diagnosed as suffering from congestive cardiac failure. Mr. Hutchinson was so deaf that any conversation was impossible - written notes and gestures were the only means of communication. He was fairly independent, walking with a zimmer frame, and was able to dress himself. Thus he enjoyed relative autonomy and was able to go to the toilet when he chose. He fitted himself into the routine: he was an early riser, often being in the day room, dressed, before the breakfast arrived. He always sat in the same place, and would spend his days reading the newspaper and gardening books (he had worked as a gardener) and actively watching the comings and goings in the ward. He always seemed cheerful, with a smile and a wave for everyone, and often a proffered boiled sweet or biscuit as well. He ate his meals with obvious enthusiasm and hearty appetite. He left the ward once a week to join a morning's gardening session, run from the day hospital. One aspect of his care was personalised: Mr. Hutchinson never sought a change of clothes on his own initiative, and washed very perfunctorily. He also suffered from dribbling incontinence. Thus although able to walk to the toilet, the nurses would actually take him there around lunch time. He also had two or three baths a week given him by nurses, and was made to change his clothes regularly. Within a milieu offering limited choices, Mr. Hutchinson enjoyed considerable autonomy and relative privacy.

Mrs. Alice Larkin. She was the least alone of Moorhouse's study patients.

As Table 5.3 shows, 56 observations featured inhumane treatment. Mrs. Larkin had been admitted from home, where she lived alone with support from family and a home help,

about a week before my three-week period of research began. Her problem was massively oedematous legs, which were 'weeping'. She had become unable to get about or into bed, thus her legs were deteriorating. She was also very large, which didn't help matters. On admission, the aim was to restore Mrs. Larkin's legs to manageable proportions, and to return her to her home. A stay of about three weeks in hospital was talked of by staff and patient alike. Mrs. Larkin's care was not primarily the product of the ward's routines. Apart from the usual landmarks like mealtimes and medicine rounds, it would have been difficult for the nurses to 'fit' Mrs. Larkin into most of the routines, since she posed, at the outset, major care problems and, later, control problems too. The care problems stemmed from having to nurse an extremely large, immobile woman in bed - her legs had to be permanently elevated, and rapid improvement showed that bedrest was efficacious for the legs. But Mrs. Larkin needed four nurses to lift her, and really the bed was too narrow - thus her position was changed little and infrequently, and she developed a massive sacral pressure sore. Mrs. Larkin was then in considerable pain, and also grew increasingly anxious over what was happening to her, as also did the many friends and relations who visited her. The care problems were now formidable: it was imperative to get Mrs. Larkin off her sacrum and to remobilise her if her sore was to heal. However, her size, the condition of her legs, severe immobility, anxiety and pain together seemed to render an active treatment programme unworkable. Getting Mrs. Larkin to sit out of bed as a means of changing her position seemed a failure. No chair was really wide enough for her, and she soon slipped down on to her sacrum again. This increased her pain and anxiety. She became more and more demanding. The response was to give her largactil "to calm her down a bit"; to isolate her

bed in a single side ward and to ignore her requests for help. Mrs. Larkin became increasingly critical of the nurses, commenting that she was not so stupid as to want to get herself into uncomfortable positions, and that the nurses should not blame her for this. Furthermore, she saw it as the nurses' job to help patients unable to help themselves and in pain, and could not understand why they were apparently unwilling to treat her appropriately. Latterly, the physiotherapists continued their attempts to remobilise Mrs. Larkin, but with little success. She was physically incapable of responding, and they saw their task as hopeless anyway: "they've left it all much too late. We'll have a go, but really it's a waste of time. She'll be dead in a week". They were right - Mrs. Larkin died shortly after the end of the fieldwork period.

All 12 expressions of distress (PI) were a direct result of the way she was treated in the ward, e.g. she said that the nurses had let her fall on her bottom on three occasions, that they were very rough with her, that the physiotherapists caused her more suffering than she could bear. On admission, her legs were very painful, and clearly this pain would have been suffered in hospital and at home alike - but her pain (and later, the pain of her pressure sore) evoked no response from nursing staff on 12 occasions that I observed, not even a word of sympathy (SI). Five of the seven observations of tertiary inhumane treatment indicated that the staff saw Mrs. Larkin as a big problem, two of these featuring 'victim blaming'.

Mrs. Elsie Moroney. She was the median study patient.

There was little evidence of inhumane treatment, as Table 5.3 shows. Mrs. Moroney had been in hospital for about five years. She was 85 years old. She had been looked after by her daughter-

in-law for years, and suffered from double incontinence and dementia. Her admission was precipitated by the illness of the daughter-in-law's father, and her departure to visit him abroad. Mrs. Moroney's care was highly routinised. She was given help with practically everything except feeding. Although she was able to feed herself, Mrs. Moroney didn't take much of an interest in eating and was sometimes fed by one or more nurses. Each of her days was much the same. She would be got up, dressed, and sat in a geriatric chair, tipped up to prevent her slipping, in the day room. The day was punctuated by meals, medicines and, several days a week, visits from her daughter-in-law. She was also toiletted regularly during the (almost) ward-wide toilet rounds. Usually she was put back to bed straight after the evening meal, which arrived around 5 p.m. She was able to talk, but seldom did so, and it was not always easy to make sense of any remarks she made. It was difficult to tell what she felt about her experience of the ward. There were just two instances of inhumane treatment observed. Thus, as with Edwin Hutchinson, her life in the ward as compared with Mrs. Larkin, was relatively unscathed. She was much more dependent on the routine than Mr. Hutchinson as she was not mobile at all.

Resumé: The Three Strategic Patients

The routines at Moorhouse seemed not to give rise to unintended suffering for Mr. Hutchinson and Mrs. Moroney. The routines could not cope with someone like Mrs. Larkin. She was not independent enough to make use of the opportunities for autonomy in the way Mr. Hutchinson did. Her care had to be entirely personalised, and the strategies adopted were manifestly a failure, causing much suffering in the process. Like Shipton but unlike Eastwood,

Moorhouse was able to offer tailor-made 'care', but Moorhouse differed from Shipton in featuring a tailor-made programme whose processes and outcomes were almost completely disastrous - except that Mrs. Larkin's legs, the reasons for her admission, had improved vastly before she died.

Ward Sister's Interview

The consultant turned out to be unavailable for interview during the fieldwork, and was seen very much as an absentee landlord. I therefore asked the sister something about the general philosophy of geriatric care medically speaking, as she saw it. I will incorporate this into the account of the interview.

First, the ward and its patients. There are 13 male beds in one wing, and 16 female in the other. Each has two single sideways used for ill patients. Most patients are either direct admissions, or transfers from the Royal and General hospitals. There are also some rotating admissions, and holiday admissions. Most patients are confused - about three of the women are lucid, and four of the men. The general aim is to get patients fit to go home or to Part III residential accommodation - but we often don't succeed in this. Acutely ill admissions often go out, so do some of the stroke patients, after about six months' rehabilitation. Such work is more effective and thorough in a ward like this than in an acute ward. Rehabilitation of stroke patients is one of the most rewarding aspects of ward work. Much of the work is 'basic' nursing care. It is good to have a mix of patients - a handful of sensible, rehabilitation patients keeps you going and gives the staff a lift. It may be good for the other patients, too. The nurses must get involved with therapy at least to the extent of knowing exactly what therapists are doing, what patients are capable of and what they

are supposed to be doing for themselves. It's also important to know details of how patients are being taught to do particular things. Untrained staff can do most of the work that arises, but an exception is what she calls "sistering". This includes checking ward management, keeping in touch with the Nursing Officer regarding work load, getting repairs organised, and doing the off duty. Most important, it involves getting to know relatives and the general social situation of all the ward's patients. In this respect geriatric nursing is a specialty, which is broader in the social sense, narrower in the technical one, than other specialties. If you are to get patients home again, you need to know ALL about their backgrounds and home circumstances. Sister encourages relatives to participate in the work if they want to, and quite a lot do. Not only is this very helpful to the nursing staff and of course the patients, but it helps the relatives too - they can feel excluded and even guilty, and, where there is the possibility of having the patients back home, they may have many practical and emotional problems to face. Helping in hospital offers a way of beginning to identify and confront these. Involvement of relatives is also important when it comes to questions of when to treat any patients who develop acute illnesses. Treatment to promote comfort is never at issue, but where patients are confused, in poor general condition and lack families, the tendency is not to treat. But which of the doctors is on duty comes in here: if it's a doctor from another ward, who doesn't know the set-up, the norm is to initiate active treatment in order to avoid possible censure from the ward's regular doctor. Although it's an extremely fine dividing line between treatment and non-treatment, in practice there's seldom any disagreement about it.

Another general policy of the ward is to reduce to a minimum any drug treatment of patients. Many patients come into the ward on elaborate cocktails, and very often these are cut out altogether and patients are reassessed to find out what they actually need. Although there's a mix of patients on the ward, the atmosphere is fairly dynamic and treatment-oriented, there is some turnover of patients. The consultant has moods for discharging people. Some weeks he wants to discharge everyone, maybe quite inappropriately. Handling this is no real problem: sister and the senior registrar will get together after ward rounds to review decisions. The consultant is a bit of an absentee landlord and also he forgets what he decides, thus there is no problem of 'failing' to implement his decisions. If he does raise queries, there are seldom any difficulties. The consultant readily acknowledges that the sister and senior registrar know the patients far better than he does, and is prepared to go along with their judgments provided they have good reasons for making them.

Staffing. The ward should have an establishment of 11.5 nurses, but has only 9.5 (there are no learners on the ward). Sister feels that about six are needed in the mornings, four in the afternoons and evenings, but observes that these numbers are hardly ever achieved.

Objectives. As has already been noted, there's a reasonably strong rehabilitation flavour about the ward. Sister also says "I suppose I can give you the trite reply ... the patients' comfort ... and at one level that is what it's all about". She goes on to say that she needs the money the job provides and that by choice she might not be nursing at all. She sees her options as limited, and feels that geriatrics is more interesting than most specialties "because you are dealing with people not cases".

Running the ward. Sister feels she has considerable autonomy, subject to certain limitations: staff levels (see above), lack of equipment (e.g. special beds) and continual problems over supplies. Recently sister has been trying to obtain supplies of a new type of incontinence pad for the ward, slightly more costly than standard issue, but better for patients and more likely to save on laundry. Administration is not concerned about the outcome for patients, and is uninterested in laundry savings, since that is a different budget head. Sister is still battling. The layout of the ward makes it very difficult to observe any ill patients who are in bed during the day. The design of the toilets is poor, and offers insufficient privacy for non-abled users. There is only one bath - the two showers are not popular with elderly patients, unused to such things at home.

Day-to-day, within these limitations, sister says she aims to involve all the staff as much as possible in deciding about work priorities and division of labour. She feels that greater participation in this respect helps establish a feeling of commitment among staff. Sister feels that she has an important part to play in identifying what work needs to be done, but otherwise all the nurses know about the basic routine of the ward. Sister does not supervise work closely, but keeps in close touch by doing at least one drugs round a day - as well as a round of the patients when she comes on or goes off duty - and by participating in the work. She can thus assess both patients and nurses at first hand, and is readily available to answer any queries the nurses may have. Most of them know when and about what sorts of things and changes in patients they should ask for help and advice or a second opinion. (Sister didn't describe a typical daily pattern of work organisation at our first session, and when we

returned to the topic, I had been on the ward for some time, and close questioning about the daily running of the ward would have been inappropriate at that stage in the research).

To sum up. From the interview, the sister appeared to have a fairly complex view of the ward and its work. Care and treatment of people rather than cases was important. It was recognised that different types of patients might require very different things of the hospital, from active rehabilitation, through long-term 'tender loving care' to an 'easy' death. Strategies for motivating, involving and supporting the staff - through opportunities for choice and participation - had been consciously adopted.

Key Actors' Work Practices: Sister and Consultant

Ward Sister. There were no obvious contradictions between the sister's observed behaviours, and the points she made during our discussions. When she came on duty, she would usually do a round of all the patients after taking a report from the nurse in charge. As she had said, she would identify special one-off tasks to be done, and make sure that someone had volunteered or been allocated to be responsible for them - e.g. for helping a patient with re-establishing toilet habits and keeping an incontinence chart updated. She would participate sporadically in the morning's work - providing breakfast, helping patients to get up and move to the day room, toileting, serving drinks and meals. The early afternoon report session was always an important point in the day. Patients were reviewed, new work identified and allocated and nurses' queries raised. Sister was very much the leader in report sessions, but all nurses

participated actively in the discussions. During afternoons and evenings - if on duty - sister would also participate in the work. She spent quite a lot of time reviewing patients with the senior registrar, social worker and remedial therapists. She also had quite a lot of contact with patients and with relatives. This ward sister appeared to be organising the ward around a relatively patient-centred view of nursing work: "people not cases". The boundaries of her control were rather broad: she had been very successful in enlisting the senior registrar's help and support in managing the ward's consultant as she saw fit in the light of her own assessment of patients' needs. Her style - systematic and well-organised, yet participative as far as nurses were concerned and, to a more limited extent, so far as patients and relatives were concerned - was not incongruent with her views about patient care and its problems.

Consultant. He made two ward rounds during the research period of three weeks. These were attended by the sister and senior registrars. Liaison, e.g. with therapists and social worker, was organised after the round by the sister. The consultant saw any new admissions, ill patients and any others picked out by the sister and/or senior registrar. He paid attention to patients' own contributions to discussions and reviews, and indeed sought their views - at any rate of those who were sensible. Those of the patients seen by the consultant received close attention which was not restricted merely to medical matters. The consultant was usually interested in patients' home circumstances and the social contingencies associated with their medical problems, or precipitated by them. He was also interested in the details of nursing care strategies for individual patients. He was not readily available between ward rounds, but his

senior registrar was: he visited the ward at least daily, regularly seeing and discussing all patients, including long stay patients.

Resumé: Patients' Experiences and Ward Work Processes

The ward sister seemed fairly patient-centred compared with Bramlington and Eastwood in particular. Nevertheless the ward featured a series of routines for handling patients over the 24 hours. These routines worked well in the sense that work did not remain undone, and for a majority of patients, most of the time, inhumane treatment did not feature strongly: e.g. Edwin Hutchinson and Elsie Moroney. The ebb and flow of work still exhibited the features of warehousing, but of the personal type. Yet an anomaly must be noted. The experiences of inhumanity borne by Alice Larkin far exceeded those of any other strategic patient in the entire research project. So what went wrong? Alice's care was almost entirely personalised. The negative features derived from many sources. First, Alice's size was a problem in relation to effective implementation of the treatment strategy without causing side effects - pressure sores. Second, the treatment strategy itself - bedrest - made it hard for Alice to be 'fitted in' to many of the ward's routines. Third, Alice was articulate and forthright in making requests she saw as her right and the nurses' duty, and quickly came to be seen as 'overdemanding'. Fourth, as it became apparent to all that her condition was deteriorating, the large numbers of relatives and friends who visited Alice perhaps became threatening, posing unspoken criticisms of nurses for allowing 'their' Mum/Alice to suffer so much, and indeed for actually causing some of her suffering. One may speculate as to whether Alice's experiences of inhumane treatment might have been

reduced had her care been subject to greater routinisation. Being in a category on her own, Alice had no protection from the negative consequences of personalised care. Alice was a deviant case in the ward. Did her problems perhaps arise because there simply were not enough staff?

Staffing levels and patient-nurse dependency

Besides the sister, the ward's regular staff consisted of two enrolled nurses, one staff nurse, four full-time and four part-time auxiliaries. In interview, sister said the ward needed six nurses on duty in the mornings, four in the evenings. In practice, the situation was as follows:

FIGURE 5.3: MOORHOUSE STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	4.3	6	3
Afternoons	6.3	8	4
Evenings	2.9	4	2

Except for one occasion, there was always a shortfall in the evenings, and on average there was a shortfall in the mornings. As measured by the Barr dependency checklist, workload from day to day did not vary greatly. During the study period, the number of patients was between 25 and 29. All but one or two were rated as care group 2, needing considerable help with basic care. A small minority were rated care group 1, needing minimal help; and care group 3, the most dependent category (see Appendix D for details of the Barr dependency checklist).

Staffing levels at Moorhouse came closest to those at Eastwood (see Appendix H), where the ward regime and the character of inhumanity suffered by patients was rather different from that at Moorhouse. As with Eastwood, the staffing situation is not strongly deviant in comparison with other hospitals except perhaps Shipton. Since sister's stated requirements for staff were seldom met, we cannot reject the possibility that staff levels might account for inhumane treatment. But, looking at the inhumane treatment experienced by Alice Larkin, in contrast with the experience of the other two strategic patients, it seems far more likely that staffing levels are just one of a range of factors which affect patients' experiences, including physical layout and facilities of the ward, patients themselves and, most important, attitudes and behaviours of ward sister and consultant.

Care was on the whole routinised at Moorhouse, within a philosophy which emphasised that patients were people not cases. The routines gave rise to few instances of inhumane treatment for those patients who fitted in. Earlier, I argued that the inapplicability of routines resulted in Alice Larkin's exposure to the worst possibilities of individually-organised care. Personal Warehousing is the label that best fits the work process at Moorhouse.

Norton Ward

This 28-bedded mixed ward was in a purpose-built geriatric hospital. It was of the same design as Eastwood ward, with the beds arranged in four six-bedded bays, with four single sideways. It was a long-stay ward.

The strategic patients

Data on observed inhumane treatment of the three strategic patients is shown in Table 5.4. The study patients were all women, as it happened, though six of the ward's patients were men.

Mrs. Dorothy Kenyon. Of the three strategic study patients, Mrs. Kenyon, the most alone of the study patients, fared relatively well, with just two incidents of observed inhumanity. Mrs. Kenyon was 86 years old, and had been in hospital for about 14 months at the start of the three-week research period. She was a widow, and had been living alone in a warden-supervised bungalow. She had suffered from leg ulcers for some 40 years, and Paget's disease for around ten years. Her admission - initially to the nearby general hospital - had been precipitated by a fall which had fractured the femur of Mrs. Kenyon's relatively good leg. After a few weeks, it was decided that she would never be able to manage at home again, and she was duly transferred to Norton "for long term care", according to the medical notes. The nursing Kardex noted she had a large and painful sacral pressure sore on admission, for which, among other things, heat treatment was prescribed. At the time of the research, the sore (never mentioned at all in the medical notes) had healed, but Mrs. Kenyon's ulcers were still bad. She was wheel-chair bound, but highly independent. Through choice, she occupied one of the single side wards. She was able to attend to all her own personal needs, was continent and mentally very alert. She appeared to me to be rather a withdrawn character. It was very difficult to engage her in more than a monosyllabic conversation and, though she spent much of her days sitting in the company of the small number of other mentally alert patients, she seldom joined in their conversations.

TABLE 5.4: ' NORTON WARD STRATEGIC PATIENTS*

1. Mrs. Dorothy Kenyon

Most alone

No. occasions

Primary inhumanity (PI) - 2

- | | |
|---|---|
| 1 | Patient found tea undrinkable - nurse failed to add sugar |
| 1 | Patient had to queue for 30 mins. to get into the toilet |

Total = 2 observations

2. Mrs. Eliza Wainwright

Least alone

No. occasions

Primary inhumanity (PI) - 14

- | | |
|---|--|
| 1 | Patient bed-bathed twice in quick succession |
| 4 | Patient distressed, help-seeking ignored by nurses |
| 2 | Newcomer agency nurses ignorant of patient's nursing care needs |
| 1 | Request for a drink refused by a volunteer |
| 1 | Physio and domestic talked across patient's bed, ignoring her |
| 1 | Consultant promised to prescribe for bad chest, but did not do so |
| 2 | Patient reprimanded: for asking to be lifted up; for grizzling (spoken to by nurse as if confused) |
| 2 | Mealtime indignity: no napkin when spilt food; men's pyjama legs tied round neck in lieu of a bib |

Secondary inhumanity (SI) - 15

- | | |
|---|--|
| 7 | Patient appeared anxious or distressed and was ignored |
| 3 | Patient remarked that she feels unwell - remarks ignored |
| 2 | Depressed because received no remedial therapy |
| 2 | Depressed and lonely; ignored |
| 1 | Patient remarked that she hated to bother nurses and be a burden |

Total = 29 observations

Continued

TABLE 5.4: (Continued)

3. <u>Mrs. Ethel Baldock</u>		Median
<u>No. occasions</u>		<u>Primary inhumanity (PI) - 3</u>
1	Felt bored through inactivity	
1	Nurse dressed patient as she sat on the toilet	
1	Nurse changed patient into night clothes at 3.30 p.m.	
		<u>Secondary inhumanity (SI) - 3</u>
1	Felt lonely, ignored	
1	Upset because family seldom visit	
1	Patient weeping	
	<u>Total = 6</u>	observations

*See Appendix G for frequencies of inhumane treatment of strategic patients of all eight study wards.

She would often take herself to the seclusion of her sideward for spells during the day, though the nurses discouraged her from doing this. Her legs needed re-dressing each day, and this was a lengthy process. Mrs. Kenyon's physical independence, and the seclusion afforded by her sideward, meant that she was to some extent in charge of the degree to which her life in the ward was processed by routines. Apart from the daily treatment of her ulcerated legs, there was nothing very much about Mrs. Kenyon's care which was personalised, neither was there anything particularly positive about it, apart from the limited possibilities to exercise autonomy and choice.

Mrs. Eliza Wainwright. Things looked very different for this patient, the least alone.

Mrs. Wainwright was 91 years old, and had suffered a stroke three and a half months before the three-week fieldwork period. She was first admitted to the general

hospital, transferred after six weeks to Rehabilitation Ward (Norton Hospital) and after seven weeks there, transferred again, to Norton Ward, about four weeks before the research began. She had been catheterised since her first admission, and on admission to Rehabilitation Ward the medical notes remarked that she was confused, catheterised and suffering from a sacral pressure sore. The nursing Kardex, on admission to Rehabilitation Ward, said that the patient was very obese and to be put on a reducing diet. The pressure sore was designated as needing heat treatment, and it was noted that chlorpromazine was to be given as the patient was 'noisy and confused'. On transfer to Norton Ward, the nursing Kardex said that the patient was quite sensible - she was continuing with the chlorpromazine, however (she seemed perfectly sensible to me, but very very depressed, sometimes to the extent that she appeared to become oblivious to much of what was going on around her). Apart from the patient's state of mind being perceived in different ways in different records, the records - and the nursing staff - seemed pretty hazy about Mrs. Wainwright's biography. Mrs. Wainwright herself reported having lived alone for many years prior to her stroke, whereas the medical casenotes said she had been living with a daughter. The medical notes contained no entries following Mrs. Wainwright's admission to Norton Ward, though it seemed from the nursing Kardex that Mrs. Wainwright contracted a urinary tract infection: remarks about the foul smell and dark colour of her urine were made over the last three days I spent on the ward, but no action was taken.

Mrs. Wainwright could not easily be fitted into the ward routine, but neither could her care be described as personalised. Aspects of it were, but much of the 'personalisation' happened by default, and

was characterised by negative rather than positive processes and outcomes. She was very helpless as a result of her stroke, and seemed to be generally rather unwell. Her sacral pressure sore was receiving daily heat treatment from the physiotherapists. This was usually given during the latter part of the morning. Thus Mrs. Wainwright was left lying in bed - often on her back - for hours before the treatment. She was the only patient in bed in the top bay, furthest from the day room: thus her efforts to attract staff attention were generally futile.

On seven occasions, extreme distress was not even seen by the nurses and, on numerous other occasions, distress or requests for help or comfort were ignored. Once, Mrs. Wainwright was offered no dinner as the agency nurse in charge of the ward had forgotten her existence. All but one other patient were in the day room. Mrs. Wainwright found the heat treatment itself distressing and painful - she had to lie on her side, often left alone, for quite a long period. When the physiotherapists had finished, she might again be left for a long time before being washed and got out of bed. On one occasion the nurses were atypically over-zealous: Mrs. Wainwright had two separate bedbaths after her treatment! The patient eventually would be got out of bed and sat, in her night clothes, in the day room. She was often uncomfortable, and quite incapable of changing her position unaided. Her appetite was poor, and she was in any case virtually unable to eat or drink unaided - since aid was seldom forthcoming, Mrs. Wainwright made a great deal of mess. Once, she had no napkin, and another time, a pair of pyjama legs served as a bib, rendering her appearance both pathetic and ridiculous. She was treated as confused by the nurses (a number of them were agency nurses who did not know the patients) and sometimes told off when asking for help. Mrs. Wainwright seemed to me to be quite aware of her predicament e.g. on

two occasions she spoke of the absence of remedial therapy (apart from the heat treatment) and her conclusion concerning its withdrawal, that she had been assessed as having no hope of improvement in her condition. Altogether, 27.8% observations of Mrs. Wainwright featured inhumane treatment. Indeed, I can find little evidence of any positive experience for this unfortunate patient.

Mrs. Ethel Baldock. She was the median patient in terms of observations when alone and six observations featured inhumanity. Mrs. Baldock was 94 years old, and had been in hospital for over three years. She had been admitted at the request of her GP, suffering from "forgetfulness", and apparently becoming less and less able to care for herself - she had lived alone. Thus her diagnosis on admission was "senile dementia, social problem". She had also had a catheter when admitted. At the time of the research, she no longer had this, but it seemed that doctors and nurses had incompatible opinions about Mrs. Baldock's continence. The Kardex made regular mention of urinary incontinence, and the medical notes, of the fact that she was continuing to be continent. It is possible that both were right. Mrs. Baldock might well have been continent, had she been regularly offered the opportunity to go to the toilet. She was very confused, and perhaps unable to recognise her needs to urinate and to take action - but there were days when she had no accidents, days on which she was taken to the toilet more frequently than usual. Mrs. Baldock suffered relatively little inhumane treatment. She was a very pleasant, yet quiet lady, and fitted into the nurses' routines. It could almost be said that ward routines were geared to such patients as Mrs. Baldock. Her days were all much the same. After breakfast at the bedside, she would be got up, dressed and walked to the day room. She was able to

walk unaided, but unless accompanied, never moved by herself from one part of the ward to another. She would spend the day in the day room. The time was passed by meals, drinks and sporadic trips to the toilet. She was led back to the bedside after the evening meal, and helped back to bed.

Resumé: The Three Strategic Patients

The ward routines - to be described more generally in the context of data from interviewing the ward sister and observing her at work - were such that relatively little unintended suffering was experienced by Mrs. Kenyon and Mrs. Baldock as a direct result of their hospitalisation. Mrs. Kenyon's functional independence enabled her to exploit to the full the ward's limited opportunities for autonomy. Mrs. Baldock simply fitted in. The issue of whether or not she was continent suggests a lack of attention to the possibility that a personalised care strategy might have been indicated. There is a parallel here with Mrs. Wainwright. In her case written records, as well as conversations I had with staff, suggest there were differences of opinion as to her mental state. Nobody seemed to recognise this state of affairs and act to clarify matters as part of a process of initiating an appropriate personalised care strategy for Mrs. Wainwright. The possibility that she was depressed had not apparently been considered at all. Mrs. Wainwright did not fit in to the ward's pervasive routines and, with the exception of heat treatment, such 'personal' care as she received was serendipitously provided, accompanied by considerable evidence of inhumane treatment. Mrs. Wainwright's experiences bear some comparison with Alice Larkin (Moorhouse) and Jack Satchwell and Horace Birt (Eastwood). Alice Larkin and Eliza Wainwright had in common the fact that neither 'fitted in'. At Moorhouse,

the response was a (disastrous) series of tailor-made treatment strategies, in contrast to the (non-routine) 'care-by-default' approach at Norton. The latter shares something of the flavour of Eastwood: nobody seemed to know or understand the particular concerns of Jack Satchwell and Horace Birt, and no positive steps were taken to clarify things and initiate appropriate responses - the processes and outcomes of 'care' were ad hoc, to say the least.

Ward Sister's Interview

There were two sisters on the ward, of whom I interviewed only the senior sister. First, her perceptions of the ward's patients and the nursing care requirements. The 28 beds - six male, 18 female and four single sideways - are nearly always all filled. The patients in the ward at the time of the research are 'typical'. Most are admitted from the rehabilitation ward at Norton, or from one of the two acute geriatric wards at the nearby general hospital - there are no direct admissions. Since about one year before, all admissions are here for care until they die. Before that, there were some rehabilitation patients who were sometimes discharged to Part III accommodation. A lot of the nursing work is of the so-called 'basic' type, though on occasions there may be technical work arising from the active care of an acutely ill patient. The general policy at present is not to be very active about treatment incidents of acute illness among long-stay patients. The aim is to keep them comfortable - sometimes very ill patients recover even without the help of antibiotics. The most common nursing care problems are to do with large numbers of very heavy dependent patients, restless patients who might injure themselves and demented patients who wander. Sister sees geriatric nursing as a specialty. Patients need far more attention than younger people. Hospital admission is very traumatic

for the elderly. Work is time consuming, heavy and repetitive and nurses need extra patience for it - it just doesn't suit a lot of people. The individuality of elderly patients tends to get lost on general (as opposed to geriatric) wards. The nurses seldom get involved with remedial therapy - basically there isn't much to get involved in. The only physiotherapy provided is heat or ice treatments, no mobilisation. There is no occupational therapist of present. She used to supervise patients who were re-learning how to dress themselves, but now this is pointless. There are so few staff, there is not enough time to let patients dress themselves. However, it is important to try and mobilise patients as much as possible, e.g. walk them to the toilet rather than take them in a wheelchair.

Staffing. Besides the two full-time sisters, the ward has an enrolled nurse, three full-time and two part-time auxiliaries, and usually two or three learners - at the time of the study, one student and two pupil nurses. There are not enough staff, and things are going from bad to worse. At one time there were four trained staff on the ward according to the sister. As a minimum, she feels six are needed on duty in the mornings, four in the evenings. There are few non-nursing staff available, apart from a chiropodist who comes fortnightly, as also does a barber. Between his visits nurses do the shaves. There is no hairdresser now - the nurses do what they can when they have time.

The ward layout. This is satisfactory apart from lack of a separate dining area and some problems with narrow toilet doors and difficulties of privacy in some of the toilets. The ward could do with more reclining chairs, and sister would like more than six ripple beds. Ward services are all quite adequate.

Sister's objectives. Sister says she has never consciously thought about these. For patients, the aim is to keep them comfortable, pain free and to preserve their self-respect and dignity. For staff, it's important particularly to think of the learners: what types of work and teaching is possible and relevant for them. For herself, she aims to care for patients to the best of her ability, and to avoid overloading her staff.

Organising the work. Sister feels she has considerable autonomy, although in practice what she can do is severely constrained through lack of staff. Thus it's not possible to plan work, things have to be organised from one day to the next. There are well-known routines on the ward, thus sister doesn't tend to allocate work other than in general terms - e.g. to make sure that the same nurses don't do the baths (the really heavy work) several days running, and to make sure that any agency nurses know what they're supposed to be doing. She doesn't do very much supervision unless worried about a particular patient or nurse, or when learners first come to the ward and haven't yet learnt the ropes. There are no problems in having two sisters on the ward - they tend to have similar ideas, and in any case they are practically never on duty together. Sister feels that the ward runs as well as it can given chronic shortage of staff. Judgments she makes about ward performance are quite automatic: e.g. checking that patients are dry, looking at pressure areas. All staff do this, and report back. There is no doubt that things could be improved if there were more nursing staff and better access to back-up staff like therapists. The sister feels herself to be responsible primarily to the Nursing Officer.

Consultant's interview

1) General philosophy of geriatric care. This didn't emerge to any level of detail in the interview, i.e. not to the same extent as with consultants at Cranford and Shipton, for example. However, one issue which came over strongly was that the consultant, Dr. Grimshaw, felt it very important to oversee all aspects of the service personally: he was the only one involved in the service to have a bird's eye view and thus to understand all the pressures and problems. And there were numerous problems over NHS boundaries. Some of the beds he used were in a different health authority, and there were in his opinion, as well as by DHSS standards, far too few beds available in the Health District. It seemed that the shortage of beds created numerous imperatives: admissions not accepted until 'last resort' stage, discharges effected as rapidly as possible at the expense of certain calculated risks. He felt that maybe patients suffered sometimes as a result of these policies, but that this was unavoidable. The other side of the coin was that he had managed to do away with a waiting list - something he saw as essential if the service was to work well.

2. Who comes into the District's geriatric beds and how. About 80% admissions are referrals from GPs with requests for domiciliary visits. About 10% are direct admissions (largely to the geriatric beds at the general hospital) and the rest are transferred in from other specialties. (As may have been gathered from the account of patients above, a 'progressive patient care' approach was in operation, i.e. different wards were designated for particular functions: acute/assessment, rehabilitation, long-term care, with patients being moved from one to another as judged appropriate by staff).

3. The consultant's role in patient care. One of the reasons

Dr. Grimshaw felt he needed to oversee everything personally was a serious shortfall in all types of staff. Going by numbers of beds, a higher medical establishment was indicated, and there were shortfalls in nursing staff, physiotherapists and speech therapists and no occupational therapists or social worker at all! He saw himself as being in overall charge of every aspect of patients' care, and felt that all staff working with patients were in the final analysis directly accountable to him. Dr. Grimshaw saw himself as team leader with powers of arbitration where there were intractable disagreements between staff. Vis à vis the Norton Ward, which was the long-term care ward, Dr. Grimshaw said that he assigned care to the nursing staff, in effect, under his general surveillance (on average, he spent about one hour a week on the ward). The ward's patients are actively treated only if they complain of being unwell and/or have particular, distressing symptoms. The primary consideration is patient's comfort.

4. Strengths and problems of care in the Norton ward. He expects the ward sister to take charge, and generally this works well. He's able to judge how things are when he sees the patients on his ward round - important features are whether they look clean and spruce, and whether they complain. He feels the standards are very good given the shortage of nursing staff, particularly trained nurses. Dr. Grimshaw thought the ward needed a staff nurse. Dr. Grimshaw observed to me that the ward would be "one of the best you'll see".

Key Actors' Work Practices: Ward Sister and Consultant

Ward Sister. She had not described her way of organising work in any great detail, so general observation can fill in some of the gaps. When the day staff came on duty at 7.45 some of the patients had already been up almost two hours, having had a perfunctory wash and a drink at the bedside. After taking a report from the night staff, breakfasts were served at the bedside at about 8 a.m. Sister administered any medicines due, and, as she had said, allocated nurses to do baths during the morning. The rest of the morning was occupied with getting patients up and into the day room, serving food, taking patients to the toilet and offering drinks. After afternoon tea, the process began in reverse, many patients being back in bed very soon after the evening meal, served at around 5 p.m. Patients seldom left the ward, and there was no organised diversional activity. Work progressed, as sister had said, primarily by means of routines. Nursing report sessions were confined to hand-overs between shifts. Sister participated sporadically in the work, but spent some time each day behind the closed door of her office. Although there was little evidence of personal care planning, sister did talk to each of the patients at some point during the day, and was always concerned about the dignity of their appearances - pulling down a skirt here, tidying hair there. When the afternoons were quiet - as they often were - she would sometimes produce a tin containing sweets or home made buns which she passed around the day room. Sister's behaviour fitted well with her rather sketchy account of how work was organised on the ward - it was apparently as she had said, largely a matter of routines. Although she had remarked on the importance of 'clueing in' Agency

nurses, in fact I never observed that she did this. Perhaps in practice the expectation is that any nurse will be familiar with basic ward routines which underpin any minor idiosyncracies to be found in a particular hospital or ward, and which depend for their survival on the unchallenged application of crude general assumptions to large categories of patients - e.g. that all geriatric patients are senile, deaf and incontinent.

The Consultant. As he had said, he spent about an hour a week doing his ward round. He usually spoke to each patient, but, as he had said, never initiated any treatment (none of the patients developed any acute illness during the three-week study period). However, although he had said that any symptoms of medical problems the patients complained of would be treated, this was not in fact the case. Mrs. Wainwright (above) complained of a bad chest, and, although Dr. Grimshaw promised to prescribe something, he did not do so. Similar incidents were observed in the case of three other study patients. His behaviour fitted with his stated view that the nurses were in charge of patient care, but, in the context of such brief contact with patients and nurses, it was difficult to see how he could in practice secure meaningful accountability of the nurses to him as consultant in ultimate charge of all staff working with patients.

Resumé: Patients' Experiences and Ward Work Processes

Of the strategic patients, Mrs. Kenyon was able to manipulate sufficient autonomy as to avoid inhumane treatment and Mrs. Baldock happened to fit in quite passively with the prevailing routines by means of which the ward was largely run. But Mrs. Wainwright suffered

considerable inhumane treatment, because she neither fitted into the routine, nor provoked staff into initiating an accurate assessment of her characteristics and problems, upon which some sort of care strategy might possibly have been devised with a view to minimising this sad patient's unintended suffering. Some points of comparison with Alice Larkin (Moorhouse) Mr. Satchwell and Mr. Birt (Eastwood) have already been made above. From the two interviews and the observed behaviour of sister and consultant, it seems that work with long-term patients is seen and done in terms of Miller and Gwynne's warehousing model. As with Bramlington and Eastwood, the ward can be described as practising Minimal Warehousing. For Mrs. Wainwright (and some of the other study patients) there were times when Agency nurses who knew nothing of patients' nursing care needs were in charge of the ward and even when the ward's own staff were working, patients' physical needs and wants - e.g. drinks, toileting - were not attended to. There was a feeling of hopelessness among the staff: almost all were actively seeking other jobs, saying that the physical and mental strain of the work was more than they could take. The consultant could be said to have abdicated his responsibility, offloading more than could be taken on by hard-pressed, unsupported nurses. He himself said to me, during a ward round, in the middle of the day room of patients. "Of course, these patients are all hopeless cases. The nurses are marvellous - I don't know how they do it". The learner nurses spontaneously offered their views about working on the ward, at great length and with considerable heat. They were shocked. They found themselves liking the patients far more than they had expected (one pupil nurse became a great expert at setting the ladies' hair) but concluded that the ward was run for the convenience of the nurses and not for the comfort of the patients. In their view, many fundamentals of

good nursing were absent, notably in relation to physical care of pressure areas.

But this section can be concluded on a more positive note. Despite the applicability of the minimal warehousing model, there were instances of humane treatment, although these tended to arise despite the prevailing regime rather than because of it. Examples (which will be discussed in Chapter 8) were learner nurses' relationships with some patients, a patient's daughter, Miss Wood, working in the ward, and a nursing auxiliary who provided personalised care to many of the patients with whom she worked.

Staffing levels were said by many of those associated with the ward to be the root cause of all its acknowledged and unacknowledged problems. The steady trickle of agency nurses, many of whom worked a single shift only and were never seen again, bears witness to Norton's staffing problems. These will now be looked at in more detail.

Staffing levels and patient-nurse dependency

Earlier, it was noted that the sister felt that six staff were needed in the mornings, four in the evenings. The situation was as follows.

FIGURE 5.4: NORTON STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	5	6	4
Afternoons	4	6	3
Evenings	3	4	2

These numbers included one or two agency nurses, more often than not, during mornings and evenings, particularly at weekends.

The ward's 28 beds were full throughout the research period. Using the Barr checklist (see Appendix D for details) the majority of patients fell into care group 2 (needing considerable help with personal care) with a small minority in care group 1 (minimal help) or 3 (total nursing care). On average, the sister's idea of appropriate staff numbers were not met. Even when her expectations were met, an unfamiliar Agency nurse, however skilled she might be, simply did not know the ward or the patients, thus as 'a pair of hands' was almost bound to be less than ideal compared with a regular ward nurse. Looking at the staffing levels of other hospitals described earlier (see Appendix H for summary table), Norton does not look dramatically deviant considering also the patient-nurse dependency characteristics of the ward. (Shipton is perhaps an exception).

Conclusion

If every ward's troubles could be attributed solely to inadequate nurse staffing levels, then one might expect to find similar quality and quantity of inhumane treatment. However, the case studies of each of six wards presented in this and the preceding chapter shows that despite many shared characteristics among wards, each has distinctive characteristics. These features have been charted in very negative terms: inhumane treatment of patients and, in some happier cases, absence of inhumane treatment. The differences amongst the wards suggests that the negative features which were observed cannot be fully accounted for by staffing levels which were judged by ward staff to be inadequate. In fact it may seem almost surprising that wards which have many differences in their ways of processing patients, have comparatively undramatic differences in staff numbers relative to patient-nurse dependency, with the exception of Shipton.

Now that data from six wards has been presented, some defining characteristics of Personal Warehousing and Minimal Warehousing, drawing on Miller and Gwynne (1972) can be listed in Figure 5.5.

The next chapter describes the last two study wards. An analysis of the antecedents of inhumane treatment of patients can be put forward once data presentation is completed.

FIGURE 5.5: FEATURES ASSOCIATED WITH PERSONAL AND MINIMAL WAREHOUSING
IN GERIATRIC WARDS

Feature	Personal Warehousing	Minimal Warehousing
1. Formal organisational authority and responsibility for performance of care task	Doctor	Doctor
2. Legal responsibility for performance of care task	Doctor	Doctor
3. Informal responsibility for performance of care task	Nurses by delegation	Nurses by default
4. Implicit definition of the care task	Valid in its own right	Failure of medical cure/ discharge system
5. Ward sister's strategy	Tendency for care to be partially pro- duced by routines, and partially managed in rela- tion to individual needs	Tendency for care to be produced by operation of inexorable routines
<u>Care outcomes for patients</u>	Routinised, batch processing; some individualisation	Routinised, batch processing

PATIENTS' EXPERIENCES AND SOCIAL RELATIONS
IN GERIATRIC WARDS
(TWO VOLUMES)
VOLUME II

Helen Kay Evers

Thesis submitted for the Degree of Ph.D., University of Warwick,
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CHAPTER SIX

TWO DEVIANT CASES

District Ward

District was a mixed ward with 31 beds. As the analysis will show, there were a number of consequences contingent on District's role as a mainly acute ward, located in the general hospital, which admitted a substantial number of emergency cases and discharged 'cured' patients quite regularly. During the fieldwork period which spanned about a month, there were 20 admissions, seven discharges and 12 deaths. There was also a small number of patients who had been on the ward for several years, the last members of a population dating from a period when a less active approach to geriatric medicine was the norm, and District Ward had provided largely long-stay custodial care, by all accounts.

The Strategic Patients

Although some of the long-stay patients were included in my study group, none of these emerged as a strategic patient. I will refer to particular aspects of their experiences on the ward in a later section, when discussing patterns of work as revealed by ward sister and consultant interviews, and the observed behaviour of these key actors.

Mr. Costa Makris. This patient was alone for a greater proportion of observations than all other study patients.

Table 6.1 shows that over one-fifth of observations featured some kind of inhumanity. Mr. Makris, who was 75 years old, had been admitted about a month before the start of fieldwork. He came into the ward as a result of a 999 call from his wife, but he had previously been

seen at home by the consultant on two occasions; the first time two months earlier, and the second just a week before his admission. On the first occasion, the consultant observed that the patient was mobile but falling frequently; needed help with most activities of daily living; was incontinent of urine; showed evidence of intellectual impairment and that his wife - who suffered a chronic chest condition - and son had no help from services. On the second occasion, the wife was requesting permanent hospital care and was still receiving no help, despite, according to the consultant, a worsening of Mr. Makris mental state, regular disturbed nights and now, incontinence of faeces as well. It was also noted that Mr. Makris had left his wife for another woman, and returned about six years earlier when he first began to be ill. It was the consultant's intention to refer the patient for admission to a special residential home for the elderly mentally infirm, but Mrs. Makris' 999 call precipitated hospital admission. On admission he was diagnosed as suffering from brain failure, and the prescription "for nursing care" was made in the medical notes. Mr. Makris was up and dressed during the day. He was a Cypriot and talked incessantly, at night as well, in Greek. When free to do so, he wandered around a great deal during the early part of fieldwork, sometimes falling. Later, he became unwell and much less active. Chemotherapy and physical restraint in a geriatric chair were used - not always successfully - as an antidote to wandering. Three instances of primary inhumanity featured physical restraint, and one instance of tertiary inhumanity was that night staff reported seating the patient in a geriatric chair all night to control his wandering. On one consultant's round, a lengthy discussion about the patient took place in his presence, but all the participants behaved as though the patient was not there,

TABLE 6.1: DISTRICT WARD STRATEGIC PATIENTS*

1.	<u>Mr. Costa Makris</u>	Most alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 4</u>
	3	Physically restrained in geriatric chair
	1	Consultant discussed patient during ward round in front of him, but did not speak to him
		<u>Secondary inhumanity (SI) - 9</u>
	9	Appeared agitated, restless and distressed: Ignored by staff
		<u>Tertiary inhumanity (TI) - 6</u>
	1	Consultant avoided discussing patient at case conference
	1	At nursing report session, conflicting ideas about effects of drug therapy remained unresolved
	1	Night staff report: patient's nocturnal wandering to be controlled by sitting him out of bed in a geriatric chair
	1	Reported (in report session) to be wandering (when I had not seen him do so during a whole day)
	1	Moralistic censure of patient's past behaviour (nursing report session)
	1	Unresolved dilemmas about the patient's future and the hope that 'events will overtake us' - i.e. that the patient would die soon (nursing report session)
		<u>Total</u> = 19 observations
2.	<u>Mr. Fred Wagstaff</u>	Least alone
	<u>No. occasions</u>	<u>Primary inhumanity (PI) - 1</u>
	1	Patient said nobody has told him what was planned regarding his discharge from hospital
		<u>Secondary inhumanity (SI) - 9</u>
	5	Felt low and depressed, ignored by staff
	1	Doesn't understand what is wrong with him
	3	Worried and upset about the idea of going home - ignored by staff

Continued

TABLE 6.1 (Continued)

Mr. Fred Wagstaff

No. occasions

Tertiary inhumanity (TI) - 4

2

Patient's depression and tiredness discounted as (a) irrelevant (b) malingering, in nursing report sessions

2

Patient's behaviour (gloom and tiredness) and conversation labelled by consultant as "bizarre" and "thought disordered"

Total = 14 observations

3. Mr. Harry Willis

Median

No. occasions

Primary inhumanity (PI) - 3

1

Reported nurses refused to allow him to return to bed although he was cold - wearing only pyjamas - and feeling unwell

1

Reported extreme annoyance at being repeatedly asked the name of his next of kin by nurses who refused to believe he had none

1

Uncertainty about what the ward had organised for him

Secondary inhumanity (SI) - 2

2

Worried about going home because of loneliness, reluctance to depend on neighbours: his worries not picked up by staff

Total = 5 observations

*See Appendix G for frequency of inhumane treatment of strategic patients of all eight study wards.

e.g. nobody spoke to him. All nine instances of secondary inhumanity featured Mr. Makris appearing extremely agitated and restless - perhaps due to his illness - but being ignored by staff. I observed six instances of what I considered to be tertiary inhumanity,

These are summarised in Table 6.1. It will be seen that some of these imply that Mr. Makris posed some insoluble problem for the staff: the consultant didn't wish to discuss him further despite the nurses' formidable problems in controlling and containing the patient's behaviour; problems about drug therapy were never sorted out; Mr. Makris was judged to "deserve" his fate because of his poor treatment of his wife; and early death was hoped for because otherwise "... what on earth are we going to do with him?" (nursing report session). As it happened, Mr. Makris developed a chest infection which was not actively treated, and he died towards the end of the fieldwork period.

Mr. Makris' case is a very interesting one. Although he came into District as an emergency, his diagnosis and behaviour seemed to suggest that he was a potential candidate for long-term care: not a task which ward staff saw as legitimate except in relation to those long-stay patients they had already cared for for a long time. They tried to move him out to a psychiatric bed, but a referral to a psychiatrist was not a success in that respect. Some active treatment and control of Mr. Makris' urinary incontinence was attempted at the outset, but, when judged not to be effective, this was abandoned. Perhaps what I observed as staff's repeated inattention to Mr. Makris' manifestations of extreme distress reflected their feelings of incapacity to do anything constructive for him which would at the same time provide them with some reward such as greater control over the patient or improvement in his condition. Mr. Makris' death provided a welcome release.

What I observed of Mr. Makris' experience in the ward featured various types of inhumane treatment, and I have argued that this can be

understood partially in terms of his being a misfit on a ward which did not welcome potentially long-stay patients. I will take up the idea of fits and misfits later but in the meantime, what of the other two strategic patients?

Mr. Fred Wagstaff. He was the least alone of all study patients.

. Just under a quarter of my observations of this patient featured inhumane treatment, the details of which are summarised in Table 6.1. The total - 14 - is less than the 19 instances observed for Mr. Makris; the total number of observations I made of Mr. Wagstaff was limited to 59, fewer than for other study patients, because he was both admitted and discharged during my fieldwork on District Ward.

Mr. Wagstaff, who was 77, was admitted as a GP emergency following a request for a bed from his GP. He had been ill for three or four days with "Flu", and had then apparently become confused and refused to eat or to take his antibiotics. He was diagnosed as suffering from pneumonia, and a variety of laboratory investigations and active treatment was commenced. In a few days, Mr. Wagstaff began to look a little better, to take some food and to do more for himself. But he seemed just as depressed as he had been when admitted and acutely ill. He complained of feeling tired, of not wishing to return home and often said that he would prefer to die. The staff knew about this, but seemed to regard it as inappropriate behaviour (given his vastly improved physical condition) which could be discounted. All the instances of secondary and tertiary inhumanity which I observed had to do with this. In the latter category, nursing report sessions twice concluded that Mr. Wagstaff's apparent depression and tiredness was irrelevant given his dramatic physical improvement; and twice the consultant described the patient's

behaviour as "bizarre" and his speaking of death as "thought disordered". Clearly I would not wish to make any kind of judgment about a medical consultant's opinion. However, I did observe that during a ward round immediately beforehand, the patient was talking, rather indistinctly, about wishing to die now that he was unable to do so many of the things he enjoyed and unable to carry on with the short wave radio I knew that Mr. Wagstaff had been a keen radio ham, but the consultant did not. The consultant remarked on the oddity of Mr. Wagstaff's remarks about short wave radio. Could it have been that Mr. Wagstaff's half-distinct remarks had contributed disproportionately to the suggestion that he was "thought disordered" and "paranoid"?

I observed nine instances of secondary inhumane treatment of Mr. Wagstaff. Five times he said he felt low and depressed, but this was ignored by nursing staff. Once, he expressed concern about not altogether understanding what was wrong with him, but his query was not addressed; and on three occasions he expressed anxiety about the prospect of going home, but was ignored by staff. There was just one instance of primary inhumane treatment: Mr. Wagstaff knew that his discharge was imminent, but complained that none of the staff had told him exactly what had been planned for him.

Mr. Wagstaff's treatment and care in the ward was largely personalised and, in terms of his physical improvement, it was very successful. This is in contrast to Mr. Makris whose care was also personalised, but where the aims of his care were to achieve greater control over his disruptive behaviour. Mr. Wagstaff's emotional needs were apparently not addressed by the staff. Although these were

discounted to begin with, later on a number of nursing and medical staff took the view that Mr. Wagstaff's long-standing marital problems might have something to do with his gloomy views about his future in general, and going home in particular. But most of them felt they had nothing to offer which might help: thus even when his behaviour had been redefined, there were still strong pressures on staff to continue avoiding acknowledging Mr. Wagstaff's depression. The social worker was referred to, but there were no observable changes in Mr. Wagstaff's behaviour or staff views about it. A discharge date was fixed, but in the event Mr. Wagstaff's son asked to postpone it for a few days as he wished to try to "sort things out at home a bit better". This was agreed to at once, and Mr. Wagstaff left the ward looking reasonably cheerful.

Mr. Harry Willis. Personal care was also a feature of the experiences of Mr. Willis - Harry - the third strategic patient on District Ward, who was the median patient in terms of the proportion of observations where he was alone. Harry was 95 years old, and had been admitted to District Ward one day before I started my fieldwork, following a domiciliary visit by a consultant. The patient had been referred because he had suffered continuing weakness following a bout of diahorrea about six weeks before. He was normally extremely active, but had not been out of the house since his illness. In the notes of the domiciliary visit the doctor remarked "Drinks alcohol ... also on phenobarb". He was diagnosed as suffering from severe anaemia, ? cause; and mild congestive cardiac failure. Harry Willis was in bed most of the time at first. Numerous laboratory tests were done and active treatment, including blood transfusion, commenced. In less than two weeks Harry was looking much better and said he felt much better too: he was up and dressed during most of the day, but sometimes took a nap on his

bed. His improvement continued, and he was discharged home 23 days after his admission. Harry Willis was a great conversationalist, once he had begun to recover, and became something of a curiosity on the ward because of his great age and his fascinating stories of life in foreign parts. He said he had been a doctor - people weren't quite sure whether they believed him - and had worked abroad for much of his life. Harry's life in the ward featured much evidence of personalised treatment and care. His treatment was planned and constantly reviewed, and most of the time he was encouraged to decide for himself the extent to which he felt able to take care of his own personal needs, and how much time he spent up and dressed. Less than one-tenth of my observation of Harry featured inhumane treatment: see Table 6.1. Harry was full of praise for the hospital and what it had done for him. The staff appeared to be pretty successful in meeting Harry's needs and, because he was rather an unusual person, he got some privileged treatment. For example, he regularly entertained droves of visitors - friends and neighbours - although the hospital tended to discourage more than two visitors to a patient at a time. Harry was also successful in meeting the staff's needs, in that he made a spectacular recovery and was an 'interesting patient'.

Resumé: The Three Strategic Patients

The experiences of all three strategic patients provide evidence of personalised care on District Ward. Harry Willis suffered the least inhumane treatment of the three, probably because he fitted in well with the way ward staff seemed to orientate their work with newly-admitted patients: towards producing a 'good discharge'. Neither Costa Makris nor Fred Wagstaff fitted in with this perspective: Costa not at all, and Fred nearly but not quite. I observed numerous instances of

inhumane treatment in both cases. I have suggested that staff on this active, treatment-orientated ward may have avoided responding to patients' manifestations of distress when they felt they could offer nothing tangibly constructive. Further light will be shed by looking at the ward sister's and consultants' accounts of the aims and policies of ward work, and at what I observed of their behaviour on the ward.

Ward Sister's Interview

First her perceptions of the ward's patients and their nursing care requirements. The ward's 31 beds, 15 male and 16 female, are occupied most of the time. About 80% admissions are emergencies, which may come via casualty, from GPs or from the bed bureau, which locates hospital beds city-wide for emergency cases. The other 20% are admitted following domiciliary visits. There is a huge variety of patients, whose level of incapacity varies. Some are very dependent, e.g. stroke patients. During the acute stage of illness patients need considerable nursing care. As they begin to get better and rehabilitation is started, patients are encouraged to do more for themselves. Most patients are acutely ill when they are admitted. About a third return home, another third die and of the rest, some become long-stay - just a few - and others go to Part III accommodation. The only type of patient to present problems is the psychogeriatric patient who is mobile (perhaps Costa Makris was one such patient) and sometimes aggressive. Transferring these patients to more appropriate placements is always difficult due to inadequate psychogeriatric services in the city. Nursing work involves both basic and technical tasks. It is usually possible to predict how things will turn out: the patient's general condition, the doctor's opinion, the diagnosis, "How far gone they are" - all these factors are important in judging the likely outcome of hospital admission. Geriatric nursing is a specialty in that

you must always be conscious of social as well as medical needs. Multi-disciplinary teamwork makes a difference to the nurse's role, for example it entails regular nursing involvement in remedial therapy, especially at weekends. Relatives can be a problem to the nursing staff, and it is most important to get to know them. Relatives don't participate in the work very much: probably the nursing staff fail to encourage this as much as they could.

Staffing. The full-time staff consists of sister, three enrolled nurses and three auxiliaries. There is also a part-time sister, staff nurse and enrolled nurse; and five part-time auxiliaries. The ward does not take learner nurses, unfortunately, as the General Nursing Council inspection judged that physical environment in the ward was inappropriate. Sister believes the ward needs more trained staff because of the amount of skilled and technical work to be done, and because she believes that nursing auxiliaries should always work alongside a trained nurse. Sister feels the ward needs nine staff during the mornings, six in the afternoons and five - of whom at least two should be trained - in the evenings. All kinds of other staff are readily available: physiotherapists, occupational therapists, speech therapist and chiropodist on request. Ward services are on the whole satisfactory, although a full-time rather than part-time ward clerk would be a great improvement.

The ward layout. This presents major problems. District Ward is on the ground floor of a converted workhouse building. In sister's view, the ward has too many beds and is much too cramped. It also lacks storage space and adequate sanitary facilities: five toilets are insufficient, and the ward has only one useable bathroom and two showers. The linen 'cupboard' consists of curtained shelves in sister's office. The overcrowded ward is a major impediment to doing good nursing work and

effective rehabilitation. In sister's opinion, the ward's beds could be used to greater effect, achieving higher overall turnover, if there were fewer of them. (The consultants did not at that time share her view, though later bed numbers were reduced).

Sister's objectives. For patients, the main objective is "To improve their condition for that day". She aims to give the illest patients priority, though she recognises that rehabilitation patients could equally justifiably be given priority: with more staff, both could be done. For staff, sister's objective is "That they feel they are doing something worthwhile, especially the nursing auxiliaries". For herself, achieving her objectives for patients and for staff is sufficient reward. She feels the objectives are reached most of the time, given resource constraints.

Organising the work. Sister feels she has considerable autonomy within the constraints of insufficient staff and a less-than-ideal environment. Things are organised from day to day: rapid change in patients' conditions and turnover render longer-term planning difficult. In describing how she organises the work, sister emphasises the early morning report session being very important. She reviews all the patients, and plans care for each of them for that day. She then allocates the nurses to work on one wing of the ward, each wing being in the charge of a trained nurse who would be responsible for deciding priorities for her team, and allocating the nurses to work in pairs. Because the ward is so busy - there are always doctors, therapists and others on the ward, many telephone calls and much paperwork - it is more practicable for sister not to include herself in one of the two teams, but to dip in and out of the work on both wings of the ward. This

facilitates constant dialogue with all the staff regarding patient care, and easy informal resolution of any difficulties. On the rare occasions when both sisters are on duty, the senior sister says that she might spend more time participating in the work along with the staff, or she might take over the care of a small number of very poorly patients. The early afternoon would herald another report session, after which the late shift nurses would form the two teams, with the early shift nurses doing odd jobs.

The staff team. Sister feels that she and the nursing staff generally are very much part of a team, of which the prime members were nurses, doctors, remedial therapists and social worker. She finds the team works very well. There is always some blurring of role boundaries, and the case conferences provide an essential focal point for the team's work. Sister regards her main responsibility to be to the nursing officer, and second, to the doctors.

She feels that the quality of care received by the ward's patients is good. She says she can judge this in terms of whether or not all the patients have had everything that's necessary done for, or with them. Besides the general improvement she estimates would result from a reduction in number of beds and an increase in staffing levels, she would like to see all patients having their own clothes. The difficulties of organising appropriate marking and laundry systems precluded this.

Consultants' Interviews

Two of the three consultants having beds on District Ward were interviewed. It proved impossible to arrange a time to interview the third. The main points of the two interviews have already been summarised in Chapter 5, p. 138 . The two of them shared responsibility for the

beds at Shipton and both of them felt that there were major factors in common between the different wards, although the interviews were actually carried out in the context of District. Most of their opinions were mutually compatible, and the main points can be listed:

1. General philosophy of active treatment of patients admitted directly to the geriatric department; aimed towards high rates of patient turnover;
2. Consultants are leaders of the professional team;
3. Geriatric hospital wards may not be the most appropriate places to care for long-stay patients; but so long as these patients are actually in geriatric wards, it is vital that consultants visibly involve themselves in their care;
4. The trend to increasing patient turnover puts increasing pressure on other staff, particularly nurses; and there have been some problems of adjustment.

Key Actors' Work Practices: Senior Ward Sister and Consultants

Ward Sister. Observation confirmed that work was planned on a daily basis. The morning report session was important for reviewing patients and planning their care, and very often sister would walk round the ward and see all the patients at the start of her shift, alone or with the nurse from whom she was taking over. Nurses were allocated to work in the way that she described, and usually sister was in and out of the ward as work progressed. The ward was extremely busy, and there were always a number of very ill patients who received considerable attention from nurses and other staff. For the acutely ill, care did indeed seem to

be actively planned, and thereby personalised. For the minority of long-stay patients on the ward, care was also personalised: each had their own daily routines. When the ward was particularly busy, the priority accorded to them sometimes seemed less.

There was considerable informal dialogue with other people involved in patient care, remedial therapists, social worker, pharmacist and doctors, for example; and, more formally, the case conferences - weekly for each consultant - were occasions for reviewing patients' progress and the treatment planned for them, and assigning particular responsibilities to particular workers.

Co-ordinating care and treatment occupied the greater part of sister's attention. Although she stressed the importance of understanding patients' social and family circumstances and emotional needs in the interview, in practice the opportunities for paying explicit attention to these were limited. Acute work and basic care work occupied most of the nurses' time. For patients who were through the acute phase of their illness, some were receiving active rehabilitation from remedial therapy staff. Some of this was done on the ward, but lack of space caused problems, as Sister mentioned in the interview, and the adjacent Activities Room or the therapy departments were also used as therapeutic venues. This left a number of patients who were neither acutely ill nor receiving therapy. Some went regularly to the adjacent Activities Room, where they could read, knit, chat or participate in whatever the occupational therapist might have organised. But for others there was little to do and nowhere to do it. The men's wing lacked a day area, and the women's day room doubled as dining room and major thoroughfare. At least there was always plenty to watch.

Besides lack of recreational and social space on the ward, the legacy of the workhouse laid constant snares for hardworking staff, as sister had pointed out. In the mornings particularly, when patients were being got up and the ward was filled with trolleys, the central passageway down the ward was often completely impassable for some time. It was hard to avoid disturbing patients under these circumstances, e.g. Mr. Gould who was blind, deaf and extremely ill, was located near the office for ease of observation. Particularly in the mornings, the end of his bed was constantly banged by passers-by and trolleys, with seldom an attempt to explain or apologise. Mr. Gould showed signs of great distress at this experience.

As on the other wards discussed so far, District had its routines - mealtimes, consultants' rounds, shift changes - but these were less pervasive than on other wards described so far. Some routine physical processing seemed to have been scrapped in favour of personalised care strategies contingent on patients' acute illnesses, and the relatively small proportion of long-stay patients - all of whom were 'known', and who represented some continuity in a rapidly shifting patient population - received partially personalised care.

Thus the sister's behaviour and the general work process was consistent with what she had said in interview. Yet there was still evidence of suffering on this ward. One kind of patient was viewed as a misfit: the mobile and sometimes aggressive psychogeriatric patient. There was a tendency to provide personal care for patients. But care strategies for misfits like Costa Makris and Fred Wagstaff were neither successfully devised nor applied, perhaps because the ward was too busy for the sister to think through and implement one-off approaches for misfit patients.

Consultants. Each consultant carried out a ward round, followed by a case conference, every week. The style of these paralleled what I observed at Shipton for Dr. Livingstone and Dr. Burton (Chapter 5, p.142). Because there was a higher proportion of patients on District who were being actively treated and rehabilitated, more of District's than Shipton's patients were discussed and reviewed each week.

Resumé: Patients' Experiences and Ward Work Processes

The explicit and implicit priorities of this ward have to do with applying efficacious treatment and rehabilitation strategies to acutely ill patients in order to restore their equilibrium sufficiently to enable a good discharge to be made. Where patients fitted this view of the task, their experiences emerged as relatively rewarding to patient and staff alike; and their ward sojourns featured low levels of inhumane treatment: for example Harry Willis. But for some of the patients who were misfits, it was a rather different story: e.g. Costa Makris and Fred Wagstaff. Various strategies were tried by staff to render each of these men more fitting to the ward - and, in Costa's case, ejecting him on the grounds that on no count was he eligible to be a District patient. I have suggested earlier that some of the patients on other wards who were most alone escaped the worst aspects of ward-wide routines. District Ward is different: ward-wide routines were less dominant because of the pressures to personalise care for acutely ill patients suffering from a great diversity of conditions. Having the lowest level of engagement - as in the case of Costa Makris - in this ward is no guarantee of escaping inhumane treatment.

What of those few patients who were long-stay? These patients, too, were misfits. Although none emerged in the strategic group of patients, it is worth noting again that they were a minority in a ward where blanket physical care routines were not vastly in evidence, due probably to the imperatives for personalised care arising from a majority population of patients who were acutely ill. This feature of the ward, together with the minority status of the long-stay patients and their continuous presence in a shifting population, probably all contributed to a climate where nurses seemed to find it possible to treat these patients as individuals.

The data from District tend to support the idea raised in earlier chapters that personalised care can be wonderful when the patient fits the dominant view of the ward's task; but it can be hell if the patient doesn't fit and if there are either no protective routines, or the routines can't be made to fit the patient either, as in the case of Costa Makris, and Alice Larkin at Moorhouse.

The great contrast between the positive experiences of Harry Willis and the negative ones of Costa and Fred render it a priori unlikely that alleged short staffing levels can explain the findings at District.

Staffing Levels and Patient-Nurse Dependency

Numbers and grades of staff have been noted in the account of the sister's interview on p.206 . Staff numbers actually on duty during fieldwork were as follows:

FIGURE 6.1: DISTRICT STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	5.2	7	4
Afternoons	5.3	7	3
Evenings	3.6	5	3

The number of patients on this 31-bedded ward varied between 27 and 30. Usually the vast majority were rated as care group 2 - needing considerable help from nurses with basic care. A very small number was sometimes rated care group 1 - needing minimal help - and usually a small number were rated as care group 3, the most dependent category. Relative to her stated requirements - nine staff in the mornings, six in the afternoons and five in the evenings, sister found the ward was, on average, understaffed most of the time. Looking back at the staffing situation on the six wards already described (see Appendix H), with the exception of Shipton (which was rather better off for staff) there's nothing startlingly different about District's staffing levels and workload, though we should remember that the patient-nurse dependency form does not take account of the extra work accruing from rapid patient turnover (see Appendix D for details of the dependency checklist).

District: Conclusion

The predominant style of this ward can be described as Personal Warehousing. Explicit efforts to personalise patient care were much in evidence, but were not altogether successful in avoiding inhumane treatment of patients who did not fit the ward's dominant

approach, geared to the care and rehabilitation of patients who were acutely ill at the outset.

Although the ward was perceived to be short staffed by the senior ward sister, this alone cannot account for the findings at District. The other wards so far discussed, with the exception of Shipton, were also seen as short staffed. Yet there was tremendous variety among the wards regarding types and levels of inhumane treatment. This suggests that the (almost) invariably perceived shortage of staff does not explain very much about how inhumane treatment arises.

Heathlands Ward

This was a mixed ward having seven male and 14 female beds in a mixture of bays and single wards. It was housed in its own single-storey building, an old ward which had been upgraded, on the site of a geriatric hospital having a mix of similar, old-fashioned wards, and purpose-built wards. Heathlands was unique among the study wards in that it had been set up with the explicit aim of putting into practice some of the guidelines set out in Elliott's King's Fund publication, "Living in Hospital" (1975), which is concerned with the practicalities of improving the quality of life of people for whom the hospital has become 'home'. The ward sister's and consultant's accounts of the development of the ward regime will be discussed later. But, by way of introduction, two important features were conscious attempts to de-routinise nursing work and develop person-centred living regimes; and the decision to cater primarily for patients who were mentally alert but physically very dependent. These characteristics not only rendered the ward

qualitatively different from the others I studied, but also made fieldwork particularly challenging. There was far less of a structure to the day-to-day work; thus it was very hard to establish an observation routine which was both systematic and relatively unobtrusive. It was difficult to become 'part of the furniture' when the furniture was always moving. The fact that many of the patients were not acutely ill, and at the same time were mentally alert meant that they had both capacity and time to take an interest in what I was doing. Quite a number of patients fed me with information, sought my opinion and made suggestions about what I should write in my report. I soon found it impossible to take fieldnotes while on the ward, unless I was willing to offer them for comment and discussion by patients and staff. Thus I abandoned my observation data sheets, and made fieldnotes as and when I could, trying to focus particularly on the experiences of the study patients. Thus the data from this ward is not strictly comparable to the others, and I probably had more influence on what went on in the ward and interacted more with ward participants than I did elsewhere. Despite this, the attempt at comparison with the other wards must be made just because it was rather different. Its contrasting features may, if nothing else, spark incisive comment on what the analysis so far has to say about long-term geriatric care. I analysed my fieldnotes by first counting the number of observations relating to each study patient. I then looked at the proportion of observations recorded when the patient was present but alone; from there I identified three strategic patients as before. The summary table (see Appendix A) shows that although the data were collected differently, as it happens the numbers of observations, and the proportion of patient observations when they were alone, is

TABLE 6.2: HEATHLANDS WARD STRATEGIC PATIENTS*

1. Mrs. Mabel Stockton Most alone

No. occasions

Primary inhumanity (PI) - 3

3

Patient clothed in a ridiculously short dress

Total = 3 observations

2. Mr. Thomas
 Westland

Least alone

No. occasions

Primary inhumanity (PI) - 8

1

Found some nurses vindictive and rough: felt some nurses treated him like a child and found this insulting

3

Nurses addressed patient as "good lad", "good boy" (you will be a) "big strong boy" (if you eat some dinner)

1

Patient excluded from decision-making during consultant's ward round

2

Patient threatened by nurses regarding his refusal to eat

1

Discussion during consultant's round, in the patient's presence, labelled him as "alcoholic" and "paranoid depressive"

Secondary inhumanity (SI) - 4

4

Patient looked miserable, said he was in pain, wished to die, ignored by staff

Tertiary inhumanity (TI) - 1

1

Unresolved confusion in a nursing report session regarding whether or not the patient should be fed against his will

Total = 13 observations

Continued

TABLE 6.2: (Continued)

3. <u>Miss D. Maxwell</u>	Median
<u>No. occasions</u>	<u>Primary inhumanity (PI) - 1</u>
1	Taken against her will by a nurse to attend a service on the ward
	<u>Secondary inhumanity (SI) - 1</u>
1	Patient hadn't understood who the social worker was, what her name was, nor that a planned visit to an old people's home was to be for half a day and not a permanent stay - she was upset by all this but ignored
	<u>Total</u> = 2 observations

*See Appendix G for frequencies of inhumane treatment of strategic patients of all eight study wards.

not all that different from the other wards. This I find reassuring as I set out to analyse the data from Heathlands and relate it to the preceding ward analyses.

The Strategic Patients

Mrs. Mabel Stockton. She was alone for the greatest proportion of observations. Mrs. Stockton who was 88, was admitted to hospital over three years before my research. She had been transferred into Heathlands ward about 21 months before my research. The circumstances

of her admission were a little unusual : her husband had been admitted to an old people's home, though how this came about was not recorded in the medical notes. Mrs. Stockton was said, in the notes, to be "unable to fend for herself at home. Apparently filthy and had neglected an animal". She had been brought into hospital compulsorily, under Section 47 of the National Assistance Act (1948). The notes further commented "... cheerful, confused. ? disorientated in time and space. ... Opinion: (1) social problem (2) cerebral arteriosclerosis". What little further information the medical notes offered was interesting. Three months after admission, it was noted that Mrs. Stockton was "Mentally quite clear ... of sound mind, and competent to deal with her own affairs". But two years after admission, the patient was said to be "confused in time and place. Very doubtful if she is able to look after her own affairs". There were no further entries during the year preceding my research. Mrs. Stockton's husband had died about a month after she was admitted to hospital. She apparently had no other relatives. She was visited occasionally - just once during my fieldwork - by two unrelated elderly women, who had been near neighbours of hers.

Mrs. Stockton's life seemed much the same day in, day out. After breakfast, she would get herself up with some help and supervision from staff. When dressed, she walked to the day room, where she would sit with a group of other patients. She never seemed to engage in any conversation, but occasionally I observed some non-verbal communication. She would spend most of the day just sitting, apart from trips to the toilet (she was sometimes incontinent of urine, and needed taking to the toilet regularly, it seemed) and mealtimes, when most patients seated themselves in small groups around a number of tables in part of the day

area. She took herself off to bed when she chose, usually soon after the evening meal was over, at around 6.30, and, with some help and supervision from staff, got herself ready for bed. She was said to be stone deaf by all the staff, and it was accepted that she was "confused", and said to be living "in a world of her own" (nursing Kardex). I never managed to engage her in conversation and in the absence of evidence to the contrary, took the nurses' definitions for granted until, on my last day of fieldwork, I spoke to her visitors. They told me she was not all that deaf, and perfectly capable of hearing what she wanted to hear. If true, this observation suggests that Mrs. Stockton, during her years of hospitalisation, had developed a definite strategy for minimising her engagement and incorporation into ward life. Certainly, in common with most of the patients who were most alone in the other wards I studied, Mrs. Stockton's life featured minimal evidence of inhumane treatment. Table 6.2 shows only three observations featured inhumane treatment. All of these occasions concerned the nurses' tendency to clothe the patient in short dresses, which looked ridiculous . Although my observations showed no evidence about positive quality of life, at least the ward's strategy of organisation - away from routines and towards 'normalising' the living environment - permitted Mrs. Stockton to follow her own established routines.

Mrs. Stockton was one of the 'inherited' patients on the ward. When the ward opened, it had proved necessary to compromise over one of the plans: to take only mentally alert people either as direct admissions from home, or transfers after a relatively short sojourn in an acute bed. This policy was aimed for as staff felt their plans would founder if they started off with a lot of patients who were both significantly cognitively impaired, and institutionalised. Some staff felt this

compromise - accepting internal, long-stay transferred patients, some with definite cognitive impairment - caused huge problems, though not all held this view. However, these patients - of whom Mrs. Stockton was one - tended to have more of a routinised kind of life than did other patients, who fitted more closely with the desired admission criteria. Because of my snapshot-type research, it is not possible to say whether these patients' routines were actively imposed by staff - though I suspect they weren't - or whether they were simply perpetuations of institutionalised routines grown familiar during months or years of living in another 'conventional', geriatric ward; a more likely explanation, I feel, from what I observed of Mrs. Stockton's pattern of behaviour in the ward.

Mr. Thomas Westland. The experiences of the second strategic patient showed evidence of largely personalised care. Mr. Westland was not an 'inherited' patient, and had been regarded as fitting the ward's criteria for admission, though this opinion was to change, as I will show below. This patient, the least alone of all the study patients experienced inhumane treatment as shown in Table 6.2.

Mr. Westland, who was 82, had been admitted to the ward 13 days before I began my research. His hospital career had begun four months earlier, when he had fallen at home and fractured his femur. This had been pinned and plated, and rehabilitation was subsequently carried out at another hospital. After a very short spell at home, Mr. Westland had fallen again, and was readmitted. From the medical notes, it seems that there were continuing problems thereafter: Mr. Westland made very little progress, and complained of pain in his hip and leg. He was referred to a geriatrician. He was apparently recovering from a chest infection

when he was admitted to Heathlands in a rather ill condition. At that stage, treatment of his illness, further investigations and assessment seemed to be the order of the day. It was noted that Mr. Westland seemed "severely depressed but orientated". The nursing Kardex, on admission and throughout the fieldwork period, remarked on the dreadful state of Mr. Westland's pressure sores: on his buttocks and, in a worse condition, his heel. From the medical notes and the kardex immediately prior to my research, it seemed that Mr. Westland was very ill with bronchopneumonia, and eight days after admission the consultant had noted "... outlook is poor, I feel". Another eight days after that, Mr. Westland's chest had improved, though he reported feeling ill, low and wishing to die, and was refusing to eat. The multi-disciplinary discussion during the consultant's ward round, at which the consultant was very much the primus inter pares, concluded that the emphasis was to be on rehabilitation as a realistic goal - though it was recognised this might take a long time. Mr. Westland's refusal to eat engendered much discussion. Without food, his general condition and pressure sores would be unlikely to do anything other than worsen, and then the whole notion of rehabilitation would be in jeopardy. Shortly after the round, the consultant told the patient's niece of his intentions, but expressed doubts as to whether Mr. Westland would ever be well and independent enough to manage at home - where he had lived alone - again.

Thirteen observations featured inhumane treatment. All these instances emanated from the consequences of the consultant pressing for an energetic rehabilitation strategy. Table 6.2 summarises the observations. There were eight instances of primary inhumane treatment. On three occasions, nurses spoke to Mr. Westland patronisingly, as though he were a child, in their attempts to cajole him to eat; twice, he was

threatened by nurses for refusing to eat. Although the nurses, speaking among themselves, found Mr. Westland's non-co-operation quite a problem for them, they were not unsympathetic towards his stance. The amount of pressure they put on him oscillated from almost none to a great deal. One of the enrolled nurses took the view that Mr. Westland was not a child, and that if he chose not to eat and thus to hasten his demise, that was up to him. She herself acted on this assessment, and expressed - though not to the man himself - anger at the consultant: she believed he had no idea "what goes on here", and that it was senseless to pursue a course of action which seemed to her quite inappropriate, just because the consultant had said so.

In one lengthy conversation I had with Mr. Westland, he said that although some of the nurses were gentle and kind, he found some of them very rough, causing him a lot of additional pain. He said that his pain-killing drugs were not always given on time, making life worse for him. He went further: he described a minority of nurses as "vindictive", in that they would make patients wait for a long time before meeting a request, e.g. to be taken to the toilet. In his case, he said that sometimes he felt he had to shout for help, and then he was told off like a child, which he found "insulting - after all, I am 82 years old".

Sometimes Mr. Westland became confused, although to me he seemed quite lucid (perhaps too much so for his own good!) most of the time. The staff said - and I too experienced this - that he sometimes made suggestive remarks and attempted to touch them in inappropriate ways: thus unfortunately for him, Mr. Westland also became labelled as a 'dirty old man'. Although there was no evidence that this affected the kind of treatment he received, it seemed, together with his refusal to eat, to hasten the general loss of patience and discomfiture Mr. Westland occasioned in the ward. On the last ward round before I finished my

fieldwork, Mr. Westland's requests for whiskey during the intervening period engendered a discussion which concluded with the view that he should be treated as an alcoholic. Sister reported his obsession with euthanasia, and the consultant suggested he should be treated as a paranoid depressive. All this in the patient's presence, but without his participation. After the ward round, the consultant sadly said that he thought admitting Mr. Westland to the ward had been "a ghastly mistake". During the remaining two days of fieldwork, there was no evidence to suggest a shift or a clarification of the care strategy for Mr. Westland who continued to refuse his food and to look depressed, miserable and often cry out in pain, especially when he was being handled by nurses. There were four instances of secondary inhumanity (see Table 6.2). They all featured obvious distress on the part of the patient, expression of pain and wishes to die: all were ignored by staff. As with Costa Makris at District, the nurses may well have ignored the patient because they felt unable to offer anything constructive to this man who was, after all, a misfit in their ward, even though he had been "chosen" for his potential to live up to the environment the ward wanted to offer its mentally orientated but physically dependent 'ideal' clientele. The one instance of tertiary inhumanity had to do with an unresolved debate among the nurses about how his refusal to eat should be responded to.

Mr. Westland's care was almost completely personalised, and it can be suggested that this directly contributed to the inhumane treatment he experienced. His suffering also occasioned some suffering to the nurses, as has been noted above.

The extent of inhumane treatment experienced by Mr. Westland is a great contrast to that of Mrs. Stockton, the most alone of the study patients. It is also in contrast with the experience of Miss Maxwell, the

median patient in terms of proportion of observation during which she was alone.

Miss Doris Maxwell. Like Mr. Westland but unlike Mrs. Stockton, Miss Maxwell had been 'chosen' rather than 'inherited' by the ward; but unlike Mr. Westland, she fitted rather better into the ward's *raison d'etre* and its concrete *modus operandi*. Miss Maxwell was the median study patient.

Doris Maxwell was 86 years old, and she had been in hospital for just over two years when my fieldwork began. Prior to her transfer into Heathlands Ward four and a half months before my research, Doris had been admitted to the geriatric hospital from home, where she lived alone, with some support from neighbours and the district nurse. She was managing only with difficulty, and suffering from oedematous legs which were beginning to break down, attributable to congestive cardiac failure, apparently. Peripheral vascular disease was mentioned early on, in the casenotes, and Doris's foot became gangrenous. She was transferred to a general hospital for amputation of her leg. She returned to the geriatric hospital and after six months fell and fractured her femur. This was pinned and plated in a second general hospital, after which Doris had come to Heathlands Ward. She had been fitted with an artificial leg, and in Heathlands policy seemed to be to encourage her to do as much as possible for herself - which she did. Throughout my fieldwork, she was largely independent with respect to self-care, and it seemed that her progress had exceeded initial expectations in that discharge from the ward seemed a real possibility. The consensus was that Doris no longer needed nursing care. She had kept her privately-rented house during her hospitalisation, and the subject of giving this up and moving to a

residential home was broached, both by the ward sister and by the social worker. Doris was quite upset by this, and the ward sister provided the major support. She advised the social worker about what might be the best type and pace of approach, given that it seemed no case could be made for keeping Doris in hospital indefinitely; though that is what Doris herself said she would prefer, having become used to the place, and being reluctant to face another upheaval. The support of Doris seemed fairly successful, but the sole observed instance of secondary inhumanity - see Table 6.2 - concerned a failure on the part of staff to pick up and respond to Doris's puzzlement and anxiety about the social worker and her schemes. From day to day, Doris seemed free to carry out her own routines, enlisting assistance when she needed it. She was a quiet sort of person who said she had no particular friends on the ward, yet she fraternised widely with other patients. She did not always sit in the same place, but would sometimes be found in the day room, or seated alongside the main corridor of the ward in company with one or more other patients, watching the comings and goings. The only instance of primary inhumanity I observed was when Doris was almost frog-marched from the corridor into the day room to attend the Chaplain's weekly service. She said she did not wish to go: the nurse's view was, "you always go, therefore you must go today: the only reason you are not going is because your leg is hurting you a little bit, but it's good for you to keep on the move and not sit down just here".

For Doris Maxwell, then, the unregimented - in parts - regime of the ward enabled her to have considerable autonomy day to day: though not security of tenure (she was eventually discharged to a residential

home, some time after I finished my research. According to sister, she had had time to get adjusted to the idea of the move and giving up her home, and when the time came, she was quite happy about it). She was a chosen patient, who fitted well with the ward's aims in that she was mentally alert but initially heavily disabled. She was independently minded, and co-operated fully in her rehabilitation programme - almost too successfully, she became 'too good' for the ward to keep her in the long term.

Resumé: The Three Strategic Patients

In a very different context, we find a rather similar story to that which unfolded in District Ward. A misfit can survive quite comfortably if minimally engaged with the ward regime: Mabel Stockton. For a 'chosen' patient whose initially-anticipated condition has behaved largely as expected, like Doris Maxwell, the ward's regime is also pretty successful in terms of low observed inhumane treatment. But for a 'chosen' patient who turns out to have been a 'bad' choice, there are terrible problems: Mr. Westland. Personalised care means, as we have seen before, reduced protection by ward-wide routines. Given Mr. Westland's characteristics, it is difficult to imagine how he would have been fitted into some of the routines that we have met on other wards. The nurses felt profoundly uncomfortable about Mr. Westland, but seemed unable to reach a consensus about changing their strategy, in the face of firm pronouncements by the consultant - even though many of them felt he had little idea about what 'really' went on in the ward. They didn't press him or challenge him when he did come to the ward, and he never told them of his revised opinion, that admitting Mr. Westland for rehabilitation had been a "dreadful mistake".

In between the consultant's rounds, medical cover was provided daily by a local GP. He spent quite a lot of time on the ward, so we now need an explanation as to why a revision of the medical strategy, and thereby the other care strategies, was not apparently initiated by him. To understand this, as I will now show, it is necessary to explain rather more about the unusual characteristics of Heathlands, set up as a deliberate experiment in improving long-term hospital life for patients. Thus I will turn to interviews with key informants: ward sister and consultant, and - remember this ward is a deviant case - the GP and the nursing officer. In looking at the discrepancies between expressed aims and actual behaviours of the ward sister and consultant, some of the problems Heathlands had with 'misfit' patients will become more comprehensible.

Ward Sister's Interview

This interview did not altogether parallel those I carried out with other ward sisters, partly because our discussions were fragmented into short conversations over a number of days.

Perceptions of patients and their nursing care requirements. Referrals come from within the hospital, other hospitals and the community. Referrals are made to the doctor, but the idea is that joint assessments should be carried out by him, the ward sister, occupational therapist and physiotherapist. At the outset, the aim was to take severely physically handicapped but mentally alert patients who would be unlikely ever to leave hospital. But assessment proved to be a very hit-and-miss affair - possibly because the aims and modus operandi of the ward are not as clearly defined as they might have been. Some patients have in fact been discharged, thus rehabilitation has become part of the ward's aims. Little

support in this is forthcoming from remedial therapists. Because the original conception was permanently resident patients, the remedial therapists were told there would be only a minimal role for them. They remember this when the nursing staff now ask for help, especially as they are overstretched anyway. Sister feels it's very hard for the nurses to act as remedial therapists because patients expect nurses to do things for them, traditionally, are already bemused - when they first come to the ward - by the expectation that self-care is encouraged with nurses playing a supervisory/supportive role, and may become quite paranoid if, in addition, the nurses start going on at them to make more of an effort to help themselves.

There is very little in the way of technical nursing work: just a few dressings. Pressure sores can be a problem because many of the patients are so immobile. She tries not to leave patients in bed unless they are very ill. Although the ward's initial ideas about clientele were compromised and a number of demented patients had to be accepted as internal transfers, sister feels that none of the patients presents particular problems. The unconfused patients help the confused ones, and everyone has something to offer. Even Harriet (a very demented patient) can play the piano and sing. It is however quite stressful for nurses to carry out intimate physical care for patients over long periods of time when the patients are mentally alert.

It is a problem to find enough men who are suitable for the ward. A mixed ward is important because it's more 'normal', but sister believes the lack of men is because when they retire and their central life routines are disrupted, they just give up.

Sister sees long-term geriatric nursing care as a specialty. The approach is different: the aim is to facilitate the development of a home-like environment and way of life, so treating people as individuals and not lumping them all together into routines is vital. Acute geriatric nursing care is more akin to acute nursing care in other mainstream specialties.

Staffing. The ward's staff consists of ward sisters, two full-time enrolled nurses, one full-time and four part-time nursing auxiliaries and two pupil nurses. During the first week of fieldwork, there were also two student nurses on the ward. Sister feels that about four nurses are needed in the mornings and the evenings. Trained staff cover at weekends is a particular problem, and very often overtime has to be worked.

Organising the work. Sister comments "Well, it just happens, really. Everyone knows what to do. We talk a lot with each other, I work with the nurses and it all just happens". There are no report sessions as such, but patients are discussed informally, which does the same job in a different way. New pupil and student nurses have the ward's aims explained to them, and sister works with them herself as much as possible till they get the hang of it: that is, the attempt is made to deroutinise nursing work, render the regime more patient-centred such that patients have greater autonomy; and to create an informal home-like atmosphere.

Problems. Major problems have been - and remain - the shortfall in staffing levels and lack of clarity about the policies and working

relationships with some non-nursing staff. The ward continues to face suspicion and even hostility from some quarters of the hospital, who believe the nurses do no work, spend all their time drinking coffee and smoking cigarettes with the patients and get privileged treatment and 'better' patients. Shortage of staff is said to be endemic, thus not only does Heathlands Ward have less than its desired numbers of staff, but like other wards, frequently has its nurses moved away for one or more shifts if shortages elsewhere are more severe. The consultant's policy seems to shift from one week to the next, but sister acts only on what she feels are good ideas.

Consultant's Interview

Part I. At the consultant's initiative, our initial discussion about his role in the ward began in the ward's office together with the ward sister. I drew the conversation to a close fairly rapidly, when it became evident that he and the ward sister had strongly opposed views about aspects of the ward's work to the extent that much heat - along with some light - was generated. The substance of this brief exchange was that both individuals felt the ward was failing. The consultant's argument seemed to be that the whole idea of creating a homely environment for mentally alert, physically handicapped patients had been irrevocably damaged by the pressures which had led to admission of long-stay, demented patients along with more 'appropriate' patients. This had been one consequence of enormous resistance to the setting up of the ward from all kinds of staff: the basic difficulty here was construed as one of attitudes. If the idea of the ward was to be salvaged, two urgent needs were, first, to seek the involvement of a clinical psychologist 'to teach us how to work together'; and second, to initiate an audit type of exercise to monitor how well the ward was doing in relation to given criteria.

The ward sister's line in this conversation seemed to be that since the idea for the ward had originated from the geriatricians, then they should have clarified the aims and operating policies to a far greater extent; rather than leaving the nursing staff to react to problems - e.g. of staffing levels, practical difficulties with the rest of the hospital - on an ad hoc basis. There had been regular policy review meetings for a while, but these had now faded out.

Part II. My second, one-to-one conversation with the consultant did much to clarify his views about Heathlands Ward. The original idea of setting up a ward offering physically handicapped, mentally alert patients a home-like environment with opportunities for greater autonomy than is normal in hospital, under the main surveillance of nursing staff, came from a Regional working party considering the problems of long-term care. At the same time, the geriatricians felt that the hospital's morale needed a boost if standards were to improve and patient turnover to increase, thereby enabling the use of the hospital's resources to provide a better service to the elderly population of the catchment area. Using the hospital to house an 'experimental' ward was seen as a good strategy for stimulating improvement in the round. Privately, the consultant hoped that this experimental ward might prove a direct stimulus to increasing patient turnover by fostering self-care and independence among patients who would conventionally have been regarded as long-stay: this part of his agenda for the ward was not shared with the nursing staff. The hope was that a successful 'demonstration' ward would serve an educational function in the hospital, and that other wards would spontaneously adopt those strategies which emerged in a positive light, and which contributed to increasing patient turnover.

As I understood it, the general idea of the ward was to provide a home-like atmosphere within which patients could exercise choice and autonomy. Nursing staff would be the key professionals, and they were to foster and support patients' autonomy through respecting the primacy of individual choice, and by providing what help was needed and asked for by physically handicapped patients. A GP would provide daily medical cover, and see those patients who wanted to see him as well as act as a consultant to the nursing staff. The consultant's weekly visit was also to be run along 'surgery' lines. Decision-making about admissions and individual patient care was to be based on joint assessment and, centrally, patient consultation; as was decision-making about the day-to-day regime and organising special events such as outings or entertainments on the ward. These ideas resonate strongly with Miller and Gwynne's 'horticultural' model of care organisation (see p. 43).

The consultant felt the ward was failing on all counts. Initial enthusiasm from local management had not been sustained, with consequent problems over staffing levels and changes in administration of other functions vis à vis the ward: e.g. provision of the evening meal an hour later than usual, at 6 p.m.; and deviations from the normal routines followed by domestic staff. The ward nursing staff were seen as overloaded, but also open to criticism for not taking more initiatives in furthering the general philosophy in practice. Stronger and more active leadership by nursing staff was seen as vital but lacking. The consultant had reverted to his traditional role, and carried out weekly ward rounds. This came about for two reasons. One of the patients had become severely anaemic, and the 'surgery consultation' system meant he did not know of this, and it had not been picked up as early as it

should have been by the nursing staff and GP: this had worried him. Further, given that the ward was operating in the context of a conventional system, he felt he could not divest himself of the formal accountability and personal responsibility for diagnosing and responding to illnesses that arose. Shared assessments of patients referred to the ward had never really got off the ground. The consultant realised that his reversion to a traditional role could be construed as a vote of 'no confidence' in both nursing staff and GP as well as the whole idea of the ward, and felt that constructive developments might follow if ward staff became so angry about this that confrontation resulted.

Perhaps to oversimplify somewhat, the major problems were seen to rest in lack of practical and ideological support from the rest of the hospital; and 'personality problems'. He was not very optimistic about the future.

Interview with GP

This was very informal, and began with his questioning the way I had gained access to the ward to do my research. Had there been real commitment to the philosophy of the ward on the part of nursing management, they should have consulted all the staff on the ward and the patients too. Instead, the ward sister had been told about my research, and asked if she would mind participating.

The GP explained his role as providing medical support to the ward sister as she requested on his daily visits, and seeing any patient who asked to see him. He was enthusiastic about the calibre of the ward's sister, and attributed the relative failure of the ward to factors beyond her control: the insistence of the hospital that some demented patients be decanted in when the ward opened; and the general lack of support. He felt that the weekly consultant's case conferences - in

which he participated - were a waste of time in that the consultant "makes the decisions anyway". He believed that there was a general failure to recognise twin stresses for nursing staff. Having to stand back from the patient to allow her to make her own decisions and care for herself is a radical departure from what nurses are socialised to do. Within this general stance, having to provide intimate physical care for mentally alert patients over a very long period of time is psychologically extremely demanding. He also believed nurses were having to make implicit unsupported decisions about the profound question of the point at which efforts to stimulate activity and independence became inhumane.

Interview with Nursing Officer

Personally, with his mental nursing background, the nursing officer was extremely sympathetic to the idea of the ward, and, in carrying out his role, he applies different criteria to this ward from the others. For example, he would not censure nurses for sitting with patients for a cup of coffee and a smoke, although such behaviour would come in for a lot of criticism from other staff. He saw his job as to absorb some of the flak, and at the same time to try to make sure the ward did not deviate too greatly regarding application of hospital-wide policies. He felt that the consultant's goals for the nursing care regime were unrealistically ambitious, given the administrative constraints under which nurses work. These include hospital-wide routines for providing meals, for administering medication, laundering clothes. He felt the ward to be short staffed, but there was nothing he could do about this. He also felt the 'inherited' patients should be transferred out, but that this would not be politic.

Key Actors' Work Practices: Sister, Consultation, GP and Nursing Officer.

Ward Sister. The day-to-day organisation of work looked much as she had described: it 'just happened'. There were routines, of course: nursing shift times, mealtimes, drugs rounds, doctors' visits and the weekly religious service. But it did appear that to some extent patients sometimes had more individual choices than I had seen on other wards. Personalised care meant that at least some of the patients were asked about their preferences, e.g. for getting up now or later; or left to initiate their own pace of self-care. Patients could - and did - choose where they wanted to sit during the day, although returning to bed was generally proscribed unless a patient was ill. There was quite a lot of social interaction among patients, and between patients and staff. Scrabble was popular with some of the patients and nurses. Some patients' relatives participated in care-work, which was generally encouraged and supported. The ward organised various 'events' - during the research, a bonfire party. Although initiated and organised mainly by nursing staff, this event attracted numerous official and unofficial participants of all ages and statuses, and was obviously much enjoyed by most of the patients.

But the ward was clearly not 'succeeding' altogether in relation to the idea of creating a home-like atmosphere and a 'horticultural' approach to care. Patients could not make their own cups of tea; most of them did not have their own clothes; and none was in charge of their own medication; to quote three rather disparate examples. The pressure of work on nursing staff which arose from the needs for physical help and care by patients also took its toll. Towards the end of most mornings, the nursing staff usually said they felt tired, and often took a coffee break together in a quiet corner of the dining

area before beginning to prepare for the midday meal. If a patient asked to be taken to the toilet during this time, it was quite likely that help would not be forthcoming. This also happened during the evenings when numbers of patients were going to bed, and a small number of staff faced considerable numbers of requests for help. There were two patients on the ward who occupied a great deal of nursing time due to their extensive pressure sores, and the need to treat these. Such stresses as these - to be found on all the other wards I studied - seemed somehow less acceptable for patients and nurses in a ward where expectations of approaches to patient care had come to be more ambitious and sophisticated. And there was evidence of inhumane treatment, as the case of Mr. Westland illustrated.

Consultant. He came to the ward weekly for his ward round. That was really the extent of his visibility on the ward, and it seemed not to be a particularly relaxed event: hardly surprising, given the changes in policy and practice concerning the consultant's role and the feelings expressed about this by consultant, ward sister and GP.

GP. His routine was much as he had described: a daily visit and chat with sister or whoever was in charge, and perhaps a consultation with one or more patients.

Nursing Officer. He was occasionally seen on the ward. His visits were very informal and low-key, and he would usually simply chat with whichever staff happened to be on duty, as well as some of the patients.

Resumé: Patients' Experiences and Ward Work Processes

The picture is rather a complicated one. From observational and interview evidence, I have arrived at a somewhat different interpretation of Heathlands' problems from that offered by any of its participants individually. Recurring themes from all the interviews were: inappropriate patients 'blocking' the aims of the ward, 'personality' problems in the professional team which adversely affected communication and co-ordination of work, insufficient nursing staff and general lack of support, even hostility, from the rest of the hospital. These last two points certainly seemed to have some substance. However, it seemed that the idea of 'inappropriate' patients offered a convenient way of avoiding, for everyone concerned, a close examination of what the 'personality problems' comprised. The long-term demented patients were a minority on the ward. They were mainly mobile and at least partially able to care for themselves with some supervision and help. Most of them were very pleasant, and able to have some kind of conversation. Clearly their capacity for informed participation in discussions about ward regime and activities was limited, yet I failed to see how these patients' problems in any way militated against putting into practice ideas about creating a more home-like, relaxed environment within which patients enjoyed certain autonomy.

It seemed to me that many of the problems had to do with the apparent assumption that, once the project had been set in motion, the nursing staff would be able to sustain and develop the basic principles, while at the same time coming to terms with a rather different kind of patient care role from that which had become established by custom and practice; and all the attendant tensions - noted earlier -

which that involved. And all of this within a distinctly unsupportive and critical environment. Because of their hierarchically and professionally subordinate status, it would indeed have been astonishing - in my opinion - had these ward-level nurses been able to resolve these issues without support and help: issues which are, indeed, fundamental to the practice and organisation of long-term geriatric care in hospital. It was also of no small significance that the idea originated from the doctors and not from the nurses themselves: they had become drawn into the scheme, and were then made in charge of its future development. Everybody felt 'let down': nurses, GP and consultant. To an extent the patients were 'let down' too: the disillusionment of the professionals with each other, which was how the professional status and function problem found expression, perhaps led all to retreat into traditional habits when faced with the complexities of a patient like Mr. Westland. Real patient-centred communication addressing his troubles could not take place without a recognition of professional, power and hierarchical dynamics which were behind those 'personality' problems, seen as obstructing attainment of the experimental ward's aims.

Staff disillusionment had a further negative consequence: criticism of self and others perhaps blinded the staff to appreciating the positive things they were in fact achieving. On no other ward were many patients regularly consulted about when they wanted to get up, whether they would like a bath or what they would like to do. On no other ward were noticeable numbers of patients so lively-minded as to render my on-the-job recording of observation data impossible, even though there were other wards where a good proportion of patients was

mentally alert. So it seemed to me that, fraught though it was with problems, the ward was achieving something by way of preserving that fragile commodity, patients' independence of spirit.

Staffing Levels and Patient-Nurse Dependency

Numbers and grades of nursing staff have been noted in the account of the sister's interview, on p.230. During the study period, numbers of nurses on duty were as follows:

FIGURE 6.2: HEATHLANDS STAFFING LEVELS

	Average	Maximum	Minimum
Mornings	4.2	7	2
Afternoons	4.5	8	2
Evenings	2.6	4	2

Sister felt that four nurses were needed during day duty, so on average, sister's expectations were met in the mornings but nowhere near met in the evenings. Patient dependency did not change from one day to the next. There was a small number of patients whose nursing care needs took up a great deal of nursing time owing to their dependency and the renewal of their dressings (Mr. Westland was one of these). Because the ward was a deviant case, I feel it is not helpful to attempt comparison and contrast with the other wards I studied. Given, however, that shortages of staff was an issue which arose regularly in connection with the ward's 'failure' to achieve its expectations, a comment is needed about the fact that, on average, morning staff levels did square with what sister said was needed. First, the morning average may be a slight overestimate. One or more nurses were regularly moved to cover other wards which were 'short'

in the mornings and, while I recorded most of these changes to the planned duty rota, there may have been some moves which I missed. The converse, staff coming into the ward to help, never took place during my fieldwork. A second point to make is that perhaps sister's expectations had been revised downwards in the light of her negative experiences and perspective on the way the experimental ward had turned out. In view of other types of data on patients' experiences and staff perspectives and behaviours, it seems unlikely that staffing levels on their own carry much weight in the attempt to unravel what was going on in Heathlands Ward.

Heathlands: Conclusion

Although this ward was very different from the others in some respects, its dynamics throw into sharp relief many of the covert tensions and dilemmas of providing long-stay geriatric care more generally. The predominant style of the ward was Personal Warehousing. But, as in other wards, patients who were misfits either suffered inhumane treatment - Mr. Westland - or existed in a highly routinised milieu - Mr. Stockton. Despite facing formidable problems, which were not altogether recognised for what they were by the staff, the ward was achieving something in the way of affording some of its patients more choices and autonomy.

CHAPTER SEVEN

OVERVIEW OF CASE STUDIES AND CROSS-CUTTING THEMES: PATIENT CARE GOALS, TEAMWORK, GENDER

Overview

1. Summary and appraisal of main research methods

The observational data collected during fieldwork on eight wards has been used to examine the inhumane treatment of study patients. Primary inhumane treatment was suffering which could be directly attributed to the fact of the patient being in hospital. Secondary inhumane treatment comprised staff's failure to respond to patients' distress which was not directly attributable to the fact of being in hospital: for example distress arising from bereavement. Tertiary inhumane treatment was discussion of, or planning for the patient, in the patient's absence, in which staff seemed to construe the patient merely as a work object.

The experiences of three strategic patients from each ward - the two patients observed to be alone the most and the least and the median patient in terms of proportion of observations where s/he was alone - were analysed in detail. Data from the whole group of study patients on each ward indicated that concentrating on these three would illustrate the range in amount and nature of inhumane treatment. The summary table at Appendix G illustrates the within as well as between-ward variations in extent of inhumane treatment of strategic patients.

Inhumanity towards patients was considered in the context of interviews with ward sisters and consultants about their views on the goals, organisation and functioning of their wards, together with what I observed of their behaviour on the ward. Staff levels and patient-nurse dependency were looked at for each ward (see Appendix H for a summary of the staffing position in the eight wards) providing scant evidence that that alone could account for inhumane treatment of patients.

My use of an inhumanity index shows the potential of this approach in describing and accounting for patients' experiences. This study also highlights some developments which could be valuable in any future use of the inhumanity index, and the final part of Chapter 8 reviews some of the possibilities for further applications of the inhumanity index. At this point, it is worth noting some general limits to the data produced by my use of the index in this study. First, my notions of inhumane treatment derived from my perspective as a social researcher and from patients' reactions to their hospital experiences. Since I am not a professional health worker, judgments about professional practices, e.g. management of pressure sores, catheter care, could not be made by me. The inhumanity index could be extended to take account of such matters.

The second general limit to my data analysis is that it does not automatically reveal inhumane treatment arising through omission rather than commission, independently of concrete evidence of patients' suffering. For example, a patient might not complain about never being offered the opportunity to have a bath, or to make her own selection from the menu, yet most people might consider this to be inhumane treatment. Some such instances of inhumane treatment do in fact emerge in my analysis, but others may have been overlooked. Having completed this study, it would be possible to construct a provisional list of kinds of inhumane treatment by omission. This could be used as a checklist during observation to ensure that data was not missed. I would not have been able to do this at the outset, but now, having demonstrated the utility of my approach through this study, future development of the inhumanity index could take account of this limitation.

The third point to note is that my observational strategy does not furnish absolute frequencies, but can only give a general indication of greater or lesser levels of different kinds of inhumane treatment. The rationale behind my observational methods is fully discussed in Chapter 3, and the findings described in Chapters 4,5 and 6 offer their own justification of my decision to opt for loosely-structured methods. I feel that absolute frequencies are in any case less important than indications of the nature of inhumane treatment, and whether it occurs to a generally greater or lesser extent. Is it not more important to know that toileting patients in public, or seating them half-naked on incontinence pads are both regular and pervasive practices, rather than to know that they happen ten times or 12 times? Having said that, I must at once acknowledge that precise frequencies might in some instances be very important, e.g. in appraising application of professionals' techniques. My approach, emphasising the qualitative dimension, has laid out the basis from which a more strongly quantitative inhumanity index might be developed. Premature quantification would run a serious risk of applying quite inappropriate categorisations which would fail to take proper account of patients' perspectives and reactions.

2. Summary of ward case studies

Chapter 4 - Cranford and Bramlington - began the data analysis.

At Cranford, we saw from interviews with ward sister and consultant that attempts to provide personal care for all patients were seen as important. Observation of these key actors at work bore out the views they had expressed and the accounts they had given of their work strategies. The least alone patient, Mrs. Charteris, was the subject of enthusiastic efforts to provide personal care and tailor-made plans for her future. But the process did not go smoothly, and the patient

experienced unintended suffering. I argued that the ward's routines failed to protect Mrs. Charteris from the negative outcomes of personal care. Although at a commonsense level as well as in professional terms, personal care is what we would all prefer, safeguards are needed against unintended negative outcomes: whether of omission, commission or confusion. The median patient, Mrs. Holdsworth, enjoyed a more routinised lifestyle in a ward regime which attempted to overlay routines with personal care for all the patients. Some of the routines featured inhumane treatment - being toiletted in public - but, more often, Mrs. Holdsworth did not quite fit into basic routines. For example, she often wanted to go to the toilet in between the regular toileting rounds, and sometimes she did not wish to go at the appointed times. Her failure to 'fit in' occasioned several instances of distress. Mrs. Corbett, the most alone of the study patients, fitted in perfectly with the routines as she seemed to be suffering from advanced dementia and might have been incapable of doing anything else apart from fitting in. Of the three strategic patients, she experienced the least inhumane treatment. But also it should be said that there was little evidence that this patient enjoyed or was capable of enjoying any positive quality of life. Drawing on Miller and Gwynne's analysis, Cranford exemplified 'personal warehousing'. Very basic physical needs were usually met quite reliably, if not always very immediately. Nursing and medical work was consciously organised with a view to taking account of patients' individuality and, although this did not always have unalloyed positive outcomes, basic affronts to the fundamentals of human dignity were not a regular feature.

This was in contrast with the situation at Bramlington. The median and least alone of the study patients experienced numerous instances of inhumane treatment. Many of these evidenced in attention to basic human dignity: a lack (sometimes total) of opportunities to go to the toilet, indecent dress, serendipitous attention to the basic physical needs for cleanliness and food provision. There was virtually no evidence of either a spirit or a practice of attempting to personalise patient care (sister's and consultant's interviews, and their observed work behaviour). The routines failed even to accomplish fundamental physical tasks reliably, and the absence of individual care meant that patients had no protection from the worst excesses of routines which frequently broke down. This was 'minimal warehousing'. The most alone of the study patients on this ward fared relatively well in terms of inhumane treatment. Minimal engagement with those effecting routines - possible because she was mentally alert and wheel-chair independent - served to protect this patient, Mrs. Batchelor.

Analysis of data from these two wards shows that amount and type of inhumane treatment are both important in appraising patients' experiences. We can begin to account for patients' experiences not in terms of the 'obvious' explanations of common resort - 'difficult' and 'heavy' patients or 'inadequate' staffing levels - but in terms of the beliefs and practices of nursing and medical staff and the relationships between these.

Chapter 5 sets out the data from four further wards, all of which is in line with the speculative explanations offered for the findings at Cranford and Bramlington. At Shipton there was on average a low incidence of inhumane treatment. But Mrs. Manfield, the most alone of the study patients, suffered twelve instances of inhumane treatment,

about 16% of total observations. Half of these featured nurses' failure to make any observable response to the patient's manifestations of distress; most of the others marked failures to afford privacy for performing basic physical functions. This ward's medical and nursing philosophy stressed personalised care, and there was evidence of systematic attempts to put this into practice. The other two strategic patients suffered minimal inhumane treatment. Routines were pervasive, but coupled with some evidence of a patient-centred approach to care. Thus Shipton can, like Cranford, be described by the term 'personal warehousing'. It seemed rather more successful than Cranford in avoiding the negative consequences of routinisation by means of strategies for personalising care. At the same time, its routines served to protect patients from possible shortcomings of personalised care. Or to put it another way, Shipton's patients fitted in quite well with the ward's somewhat flexible repertoire of patient care strategies. Staffing levels turned out to be relatively more generous than on any of the other study wards, and in line with the ward sister's ideas of what was needed. But this cannot by itself account for Shipton's relatively positive patterns of care: weekend staffing levels were lower, but there was no evidence of a different pattern of inhumane treatment prevailing at weekends. There was one unaccountable feature at Shipton: the blanket application of enema rounds. This was a foible of the ward sister's, and deplored by all ward nursing staff, many patients and medical staff.

The next ward, Eastwood, exemplified 'minimal warehousing'. As at Cranford and Bramlington, but in contrast with Shipton, the patient who was most alone suffered the least inhumane treatment. Mr. Ewing fitted passively into the routines, and all the observed instances of inhumane treatment had to do with staff belittling the

patient's account of new symptoms that he was suffering. The other two strategic patients suffered numerous instances of inhumane treatment. Their needs and circumstances seemed poorly understood and, in a ward where there was little evidence of personalised care, nobody took the initiative to clarify their respective situations and respond to them. These patients' sufferings were of a different order from that to be seen in Bramlington in that basic affronts to human dignity were not a regular feature; but both wards had the characteristic of work accomplishment which proceeded through the application of non-patient-centred routines. Both the charge nurse and consultant gave accounts of their work which centred almost exclusively on problems of resource management and control to the exclusion of patients - even explicit acknowledgement on the part of the consultant that elderly long stay patients are undesirable commodities. The beliefs and practices of these key actors, as in the other wards, seemed far more relevant to understanding patients' experiences than did any kind of 'explanation' deriving from the nature of the ward's patient population and patient-nurse dependency, or from 'inadequate' staffing levels.

Moorhouse offered another example of 'personal warehousing'. Ward life was organised around pervasive routines which were broadly applied, but within that, there was evidence of a philosophy and practice of individualising patient care. This seemed pretty successful in that Mr. Hutchinson - the most alone of the study patients - and Mrs. Moroney, the median patient, experienced minimal inhumane treatment. But Mrs. Larkin, the least alone patient, experienced more inhumane treatment than was observed for any other patient in the entire study. So what went wrong in this ward which seemed fairly successful otherwise? This patient could not be fitted into any of the ward's repertoire of

routines, and she presented the staff with formidable care problems and management problems. She was viewed as a disruptive force in relation to smooth-running routines. She was alert, articulate and critical and soon became labelled as a difficult patient. The professionals failed to identify an appropriate tailor-made strategy for her, and because she failed to fit in to any of the ward's basic routines, she was afforded no protection from a personalised care strategy which failed on every count - biologically, psychologically and managerially. The idea of patients who are 'misfits' has been seen in other wards, for example Mr. Birt and Mr. Satchwell at Eastwood; Mr. Makris at District and Mr. Westland at Heathlands. This recurrent theme will be discussed in the context of patient care goals in a later section of this chapter.

Norton is the third and last of the wards to which the label 'minimal warehousing' is applicable. Work was accomplished largely by means of routines, with little evidence of a philosophy or practice of personalised care on the part of the senior ward sister and the consultant. Mrs. Kenyon - the most alone of the study patients - was one of a minority of patients on the ward who was independently mobile (in a wheel chair). She suffered minimal inhumane treatment, like the most alone study patients from other wards with the exceptions of Shipton and District. The median patient, Mrs. Baldock, fitted in passively with all the routines, and did not experience gross inhumane treatment.

The least alone of the study patients, Mrs. Wainwright, was observed to suffer a good deal of inhumane treatment. Fitting Mrs. Wainwright into the ward routines was not always straightforward, and

some instances of inhumane treatment arose because she was a 'misfit'. Half the inhumane treatment featured the patient's appearance of distress being ignored by nursing staff. No initiative was taken to clarify a positive care strategy for this patient. This clearly parallels what was observed at Eastwood. An atmosphere of resigned hopelessness pervaded the ward. Meeting patients' basic physical needs some of the time seemed the most that could be hoped for. Again, staffing levels per se could not account for the negative features of life on this ward; though it must be said again that at times the ward was heavily reliant on agency nurses to make the numbers up. Sometimes the ward was left in the charge of an agency nurse who had never before worked there, and knew nothing of the ward and its patients: clearly this situation is not conducive to initiating and following personalised care strategies.

In Chapter 6, the two deviant wards were examined. District was more of an 'acute' ward having a high turnover rate; receiving a fair proportion of emergency admissions and being located on the site of the district general hospital. The strategic patients' experiences cast in sharp relief the question of 'fits' and 'misfits'. Here, the acutely ill patient achieving complete or partial recovery in a fairly short period is the 'ideal' towards which the philosophy and practice of the ward is geared. Thus the most alone of the study patients, Mr. Makris, suffered inhumane treatment insofar as he was, from day one, an obvious candidate for long-term care. A strategy was never worked out for him, and much of his inhumane treatment consisted of his distressed behaviour being ignored by staff. This has some parallels with Mrs. Manfield at Shipton - the only other 'most alone' patient in the study to suffer much in the way of inhumane treatment.

Although Shipton was geared to 'slow stream' rehabilitation and long stay care, Mrs. Manfield was a misfit in that her distressed behaviour - ignored by nurses - indicated that she did not altogether harmonise with ward-initiated routines. The median patient at District, Harry Willis, fitted very closely with the 'ideal', and suffered little by way of inhumane treatment. The least alone patient, Mr. Wagstaff, had the appearance of an 'ideal' patient at the beginning of his stay, but became deviant as his spirits remained low even though his body recovered. There was evidence of personalised care on this ward, but it seemed that the strategies were not always worked through clearly for patients who did not match the range of repertoires the ward was geared to producing. This ward was described as offering 'personal warehousing'.

The final ward, Heathlands, also turned out to fit the label 'personal warehousing'. It was a particularly interesting case, in that an attempt had been made to foster something akin to a 'horticultural' approach to patient care, as described by Miller and Gwynne (see p.43 above). But the changed goals had never been clearly defined, and, given a hostile environment, personal warehousing had emerged by default. This ward has fairly definite ideas about what type of patients formed 'appropriate' clients for its special efforts at creating a home-like, de-routinised and to some extent de-medicalised environment; and any patients who did not fit with the ward's 'ideal' presented challenges vis à vis appropriately personalised care strategies. For Mrs. Stockton, the most alone of the study patients, who had been 'inappropriately' inherited, life followed a set routine. But she experienced little in the way of inhumane treatment. From my snapshot view, it seemed this routinisation might have been a perpetuation of her long history of

institutionalisation, and not a routine imposed by the nurses. Miss Maxwell, the median patient, was 'chosen', and fitted well with the ward's conception of appropriate patients: the ward allowed her considerable autonomy. Indeed, her capacity for self-care exceeded expectations: she had become 'too good' for the ward. She too suffered negligible inhumane treatment. Mr. Westland, the least alone of the study patients, had been 'chosen' for the ward. But that choice turned out to have been mistaken, in the consultant's and some of the nurses' views. The patient's ill condition was responded to with personalised care, indeed he could not have fitted in to the ward's habits; but the goals of that care were never clarified. Implicitly, he was a misfit; he was also a care problem, a control problem and a 'dirty old man'. He suffered some inhumane treatment - admittedly of a much lower level than some patients on other wards - but the nature of it seemed to me particularly, albeit unintentionally, cruel.

Figure 5.5, a summary of the main features of minimal warehousing and personal warehousing wards, is shown on p.195.

The findings from this study, then, do not contradict what we know of the social processes of geriatric care from other studies as reviewed in Chapter 2. It seems that the study wards, which were regarded by no-one associated with them as remarkable for their excellence or otherwise, were not altogether succeeding in providing humane care for their patients. In my next and final chapter, I shall turn to the problem of devising new models of care. As a preliminary, I shall now look at the senses in which geriatric care in the study wards is failing in relation to public and professional policies about hospital geriatric care. The data from this study provides a basis for analysing why this failure is to be found. The tendency towards personal

warehousing found in five of the wards, and professional practices and interrelationships from the minimal wards provides the basis for a tentative analysis of factors which could make for 'better' care.

3. Public and Professional Policies on Hospital Geriatric Care

Since 1981, when I summarised these elsewhere (Evers, 1981a and b), it does not appear that any major shift in emphasis has taken place. At that time, I noted that public policies and professional statements featured a number of prescriptions which reflect the tenets of the so-called 'Activity theory' of ageing (see for example Lemon et al, 1972). Activity theory regards successful ageing as characterised by continuing activity and social participation, which in turn gives rise to high levels of life satisfaction. Public and professional policies attempt to address the dual concerns identified by Macintyre (1977): humanitarian concern for the plight of sick elderly people; and minimising the economic cost to society of services dealing with the 'burden' of the elderly. Three basic assumptions regarding the nature of hospital geriatric care seem to run through policy documents and professional literature. I summarised these (1981a, p. 582) as follows:

- "1. Active intervention and therapeutic optimism should characterise initial stages (of patient care) until 'proved' inappropriate.
2. Patients' physical and psychological independence should be promoted and encouraged (since independence is assumed both to be what people want, and to enhance quality of life).
3. Patients' feelings of self-esteem, and quality of life, are best sustained, restored or enhanced through engagement in purposeful activity."

The preceding chapters have provided data about what was found in practice in eight unremarkable geriatric wards. Because seven of these

were occupied primarily by long-stay patients, I have but little data pertaining to the first point above. In District Ward, which saw itself as having many shared features with an acute medical ward, active intervention was characteristic from the point of admission. The inappropriateness of this strategy was sometimes 'proven' - for example in the case of Costa Makris - but the ward staff responded, not by instituting a positively-defined alternative, but by applying control-orientated tactics to avoid disruption to their normal repertoire of routines.

Regarding (2) above, more can be said. At one extreme, patients' independence of action and thought was positively discouraged. For example, patients were physically restrained in geriatric chairs at Norton and Bramlington. At Bramlington, those not thus restrained were often discouraged from attempting to meet their own physical needs. Mrs. Wilder often tried to walk to the toilet, but if observed, was routinely told "Sit down, you'll fall". Even compos mentis patients were usually denied the opportunity to make their own selections from the ward's menu cards, since the ward nurses 'know what they like'. At the other extreme, patients were allowed to be independent within limits. For example, Doris Maxwell at Heathlands was almost totally self-reliant and free to programme her own day-to-day life provided she did not deviate too much from the established pattern: because she was known to attend the weekly religious service regularly, it then became not permissible for her to opt out. Although independence might be allowed - more commonly on the five personal warehousing wards - and even encouraged, this was not necessarily the same thing as allowing patients freedom of choice or action. For example,

on none of the wards apart from Heathlands could patients 'choose' to get up late without being challenged by the nurses; and even at Heathlands it was not generally permissible for a patient to choose to spend a day, or even the whole morning in bed without convincing someone s/he felt under the weather. Freedom of choice about whether and when to go to the toilet was distinctly lacking everywhere for all patients other than those who were independently mobile.

Regarding the third point above from policy on geriatric care, opportunities for purposeful activities, whether on or off the ward, were not strongly in evidence. At Cranford, there were weekly cookery sessions run by the occupational therapy aide and very occasional outings for small numbers of the patients. At Bramlington, there was no activity at all; likewise at Norton and at Eastwood, apart from the occasional film show. At Moorhouse, there were weekly sessions, for participants from all of the wards, of painting, singing and entertainment, and gardening. Some patients also visited the day hospital, as also did some patients at Shipton and Heathlands. District patients were able to use an activities room for a limited range of therapeutic and diversional activities initiated by physiotherapists and/or occupational therapists. Heathlands regularly organised 'socials', like the bonfire party, and outings; but opportunities for doing ordinary but purposive things, for example going to the pub or the shops or to church, were virtually non-existent. It could be argued that this would be inappropriate for a hospital, or that people able to engage in such activities should not be in hospital. But it would seem to me, on humanitarian grounds, that hospitals could easily facilitate such activities, e.g. through the use of voluntary workers, without detriment to considerations of 'efficient' deployment of scarce staff resources. Many patients in psychiatric hospitals are allowed to go out, so why not geriatric patients too?

Regardless of whether particular types of geriatric patient 'ought' to be in hospital or not, there they are in fact; and they should not in my opinion be made to suffer for the weaknesses of our current array of care services, which give rise to the notion of 'inappropriate' placements.

The above points, together with the data analysed in Chapters 4, 5 and 6 above, strongly suggest that at least two of the general 'prescriptions'-derived from policy and professional statements - were not being altogether fulfilled in the wards I studied.

Why was this? And why did I find so much evidence of inhumane treatment?

4. A tentative explanation of the failures of geriatric wards to match up to policy-derived prescriptions and to provide systematically humane care for patients

Negative social stereotypes of old age abound (de Beauvoir, 1972). The values of the wider society are embodied in the health care system, and the geriatric specialty is often, in practice, afforded low priority and low resources in the health service.¹ Health workers are socialised into a system which emphasises the curative powers of efficacious medical techniques judiciously applied to properly-diagnosed patients. In specialties where the opportunities for spectacular cure are fewer, the requirements of non-medical health workers - particularly nurses - are to carry out predominantly care and person-orientated rather than

¹Old people are major users of health services and they occupy around 60% of all acute non-maternity and non-psychiatric beds. But if their hospital sojourn is protracted, they not infrequently attract the epithet 'bed blocker', and very often attempts are made to move them out on the basis of their length of stay in an acute bed rather than their health status, see Hall and Bytheway (1982).

cure and disease-orientated work. In the hospital culture, dominated as it is by the medical-curative paradigm, care-work which is not directly and obviously linked to cure-work is usually low-status. Geriatrics is one such specialty; born from a legacy of Poor Law infirmaries, many of whose beds were occupied by elderly chronic sick patients. The pioneers of the specialty, for example, Marjory Warren whose work began in the 1930s, would I think have endorsed the principles underlying the three prescriptions for hospital geriatric care on p.253. Warren argued that following proper assessment, remobilisation and treatment, it was possible to rehabilitate and discharge patients previously regarded as 'hopeless cases' (Warren, 1946). The development of the specialty of geriatric medicine has probably done much to improve access of acutely ill elderly people to the diagnostic and therapeutic resources of hospital services. Geriatricians often argue that increased turnover of patients in geriatric beds is vital if a quality service to a defined elderly population is to be maintained. High turnover attracts high quality staff who do high quality cure-work. High turnover frees beds needed for rapid response to new acutely ill patients. The special understanding that specialist workers with the elderly sick have of the presentation and management of illness in old age contributes to preventing patients from becoming long-stay, and promoting revitalisation and independence; so the argument goes on. So far, so good: modern geriatrics has transformed itself from serving as the 'clinical undertaker' for other adult specialties (Kemp, 1963) to the provider of positive hope through treatment and rehabilitation of primarily directly-admitted rather than transferred patients. Modern geriatrics is largely about cure-work, rehabilitation and patient turnover. But it is also the case that many geriatric beds

- most of those in the wards I studied - are occupied by patients who have not been, or are unlikely to be, rapidly turned over. For them, care-work, primarily done by nurses, is the order of the day. Although geriatricians may recognise that a part of their nominal responsibility remains towards long-stay patients, there does not seem to be much discussion in the literature of the 'proper' role of medical care and its organisation in relation to non-dischargeable patients. However, various sources (e.g. Caird, 1982; Hodkinson, 1981) remark that long-stay care is, or should be, primarily a nursing responsibility.

And so, in practice, it appeared to be in my study. But in a medicalised arena, positive steps must be taken to ensure that care-work is practised as a valid and valuable activity rather than a residual requirement for those on whom cure-work has failed. Otherwise, high quality care-work - the kind of care we ourselves would be happy with if we were sick and dependent - seems likely to result only from individual inspiration and dedication rather than from the system of organisation.

In none of the wards I studied did care-work reliably result in provision of humane care for patients. All wards featured aspects of the warehousing model described by Miller and Gwynne. But personal warehousing wards at least showed some recognition of the value of patient-centred care; and very basic affronts to human dignity were less often seen on these wards. In these two senses, the personal warehousing ward offers a less bleak prospect on average for the long-stay patient. An important difference between minimal and personal warehousing wards derived from the beliefs and work practices of consultants vis à vis long-stay patients, and the structure of their relationships with nursing staff, in particular ward sisters.

On the three minimal warehousing wards, Bramlington, Eastwood and Norton, the three consultants concerned believed they had no particular role to play with respect to long-stay care, which they saw primarily as a nursing-care responsibility. They all saw it as rather depressing and unrewarding work; heavy, professionally uninteresting, routine and dirty work. The long-stay patients on these wards had virtually no contact with consultants or any other doctors. Since all these wards contained a majority of long-stay patients, this meant in effect that doctors were seldom to be found there, and nursing staff lacked much in the way of support from the doctors, even though the latter remained formally and legally accountable for patients; and the nurses had no such legal authority.

In the personal warehousing wards, the consultants believed long-stay care was an important and worthwhile job which should appropriately be the responsibility of nursing staff, with support from other professionals. This support was offered in one of two ways. At Cranford, the consultant regularly saw all patients, including the long-stay patients; and paid detailed attention to any new or changed medical problems they might have, discussing the situation fully with the ward sister. He also encouraged consultation by the nurses between his regular visits should they feel a need to discuss a patient urgently. This consultant expressed the view that so long as long-stay care was carried out in a medicalised arena in which consultants were legally responsible, it was vital for the consultants to be actively involved in supporting nurses' care-work if standards were to be maintained.

Consultants on the other personalised warehousing wards (Shipton, Moorhouse, District and Heathlands) also explicitly acknowledged the value and validity of long-term care-work, which they had in effect informally delegated to the nursing staff, whom they saw as the most appropriate professional workers in that sphere. They did not see long-stay patients routinely since they did not believe that medical care had any obvious role. However, they were readily available for consultation about any long-stay patient who became ill or whose condition changed in any other way, and would devote as much attention to such a patient as they might to a possible candidate for cure and turnover.

5. Conclusion

None of the study wards, then, matched up to the - in some areas vague - official and professional pronouncements about the nature of geriatric care. But some came closer than others. This section has I hope shown that the findings can be accounted for in terms of the prevailing view of geriatric care, particularly long-stay care, as low-status dirty work, with patients who present the medical care system with formidable challenges. The personal-warehousing wards, however, showed evidence of beliefs and work strategies instituted to compensate for and counteract the unremittingly negative trends prevailing in the minimal warehousing wards. But even the personal-warehousing wards remain locked into a medical care system. There are strong pressures towards routines which centre around sometimes mindless managerial goals which exclude patients' perspectives. Further understanding can be gained by exploring three themes which cross-cut the ward case studies:

1. The goals of patient care
2. Multi-disciplinary teamwork: the cornerstone of good geriatric practice
3. Gender: geriatric care is about women being cared for by women

The Goals of Patient Care

Medical notes and nursing Kardex each contained, in their own style, information about signs and symptoms, medical diagnosis and, sometimes, home circumstances. Investigatory tests or procedures would be noted, medication might be prescribed, referrals to other professionals might be made and recorded. and, just occasionally, something akin to a goal or goals of the patient's care might be noted. Mrs. Charteris (Cranford) and Mrs. Butcher (Shipton) were both described as 'for Part III', for example; implying that the goals of their care were to achieve rehabilitation to a level of independence whereby these patients would be acceptable to a local authority residential home. Another example was use of the epithet 'tlc', or 'tender loving care', a term of perhaps unintended irony, implying that therapeutic goals had been positively decided against. Seldom was any particular plan explicitly defined in any of a patient's records. Was this because enumeration of medical and sometimes social circumstances are straightforwardly and obviously linked with particular patient care goals which were precisely understood by all concerned? Clearly the nursing profession does not think so: an important part of the 'nursing process revolution', which began to be imported from North America in the 1970s, is the emphasis on patients' individuality and the need to define and monitor precise care goals and care strategies. As applied at Cranford, the 'nursing process' meant

very little other than a changed printed format for the nursing Kardex. Although the 'process' is now, in 1984, more widespread, the evidence about ensuing 'real' changes in practice regarding defining care goals and strategies, is patchy to say the least.

From my study, too, there was evidence that care goals and strategies do not 'emerge' simply from a medical diagnosis or a label like 'tlc'. Examples are the cases of Costa Makris at District, Mr. Birt at Eastwood and Alice Larkin at Moorhouse. But even though the goals of work with patients may not be clearly defined, nor strategies for attaining those goals explicitly identified, work with patients is usually purposive. This may be so either in terms of what the patient's needs are assumed to be; in terms of organisational or managerial imperatives; in terms of accomplishing familiar and routinised work processes; or perhaps all three of these. Since work is purposive, it is possible to discover the implicit purposes, to some extent, by observing ward participants at work with patients. From my field notes and patient-centred observation, I looked for evidence of whether staff talked about plans for patients' care, impending or possible discharge, whether among themselves or with patients and/or relatives. I looked for the incidence of regular, apparently therapeutically-orientated contacts between patients and non-nursing professional staff. I looked for evidence of discharge-orientated behaviour on the part of staff, for example making contact with outside service providers to assess need for home support. On the basis of these kinds of data I classified study patients' goal types. These are shown in Table 7.1. The six rapid cure patients - five at District and one at Shipton - all had considerable contact with non-nursing health professionals as well as with nurses. These staff engaged in behaviour which looked to me to be geared towards

TABLE 7.1: PATIENT CARE GOALS

	a Rapid cure/ discharge	b Eventual discharge	c Long-term care	d Good death	e Unclear/ controversial	f Revised	g Rotating admissions
Cranford	-	3	8	-	-	-	-
Bramlington	-	1	7	(1)	-	1(c) to (d)	1
Norton	-	-	11	-	-	-	-
Eastwood	-	3	6	-	1	-	1
Shipton	1	1	6	(1)	-	1(g) to (d)	2
Moorhouse	-	2	6	(2)	1	2(b) to (d)	-
District	5	-	4	1	1	-	-
Heathlands	-	1	8	-	1	-	-
Total	6	11	56	1(+4)	4	4	4

therapeutic ends, e.g. applying a blood transfusion, giving antibiotics and intensive physiotherapy for the chest and for mobility, liaising with social services and community health services in arranging support for the discharge of a severely disabled patient. These patients' lives featured quite a lot of treatment-orientated activity, and staff talked about discharge in terms of concrete time intervals.

Eleven further patients I categorised as being for eventual discharge. All these patients had regular contact with non-nursing therapeutic professionals and discharge was spoken of by staff. But, crucially, the concrete time-scale was lacking. For some patients, 'in-principle' plans without specific dates attached, were being made with community support services or residential services. For all these patients, there was some doubt in talk and behaviour about whether they would 'make it'. They differed from the rapid cure patients too in that most of them had been in hospital for several weeks or even months. Some had perhaps slipped into slow-stream rehabilitation following cure-orientated treatment earlier, before I began the research. Because all the wards apart from District had mostly long-stay patients with perhaps some slow-stream rehabilitation work also, it is impossible to speculate from my data about the cut-off factors between the rapid cure and eventual discharge categories.

The 56 long-term care patients were thus categorised because there was no talk of their possible discharge: quite the contrary, in many cases. All but two had no regular treatment-orientated contact with non-nursing professionals. One of these was receiving infra-red treatment of horrific pressure sores. The other was said by the physiotherapist to have no hope of sufficient recovery from a stroke to get home again. But treatment continued because the physiotherapist could not bear to convey this message to the ever-hopeful patient

through withdrawal of treatment. Time spent in hospital was only part of the long-term care definition. In other contexts, this has come to assume disproportionate importance because long-term care is often defined in almost exclusively administrative terms, which obviously feature concern with patient turnover and length of stay. For some patients who had been in hospital just a short time there was no talk of discharge, no obviously therapeutic or rehabilitative behaviour, and very little contact with non-nursing professional staff. The cut-off point between eventual discharge and long-term care was partially time-based. Several physiotherapists, and numerous nursing staff, agreed that up to about six months hope of discharge might be maintained, but after that the 'may-be's' usually become 'no hoppers'.

At the beginning of the research, one patient at District was acknowledged to be dying, and work was explicitly aimed towards assuring a 'good death'. Four other patients came to be viewed as approaching death during the research: treatment routines towards these patients changed as shown in column f of the table. All the patients remained in bed, and any efforts towards stimulation or rehabilitation ceased.

For four patients, care goals remained unclear and/or controversial throughout most of the period of my research. As it happens, all these four emerged as strategic patients in their respective wards. Discussion of Horace Birt, Alice Larkin, Costa Makris and Thomas Westland is on pages 148, 164, 196 and 221 respectively.

Finally, four patients were regular so-called 'rotating' admissions. An important part of this scheme was to give caring relatives a rest, thus, but for their fixed fortnight's sojourn, these patients would probably have fallen in the long-term care category.

Only District was geared towards active treatment of acutely ill patients with a view to achieving rapid discharge. Fred Wagstaff was one rapid cure patient who failed to behave appropriately in that he remained depressed when his physical condition had improved. This evoked some consternation, and the possibility of mental illness was raised. Although the ward had a small number of long-stay patients, these had all been in hospital for a number of years, and had been inherited from an earlier long-stay orientated geriatric service. They were an accepted part of the ward, but ward staff were not prepared to allow other patients to deviate from this discharge - or death - trajectory. Costa Makris was an example of this, in that when ejection attempts failed, a custodial strategy was instituted, until death fortunately intervened.

Slow-stream rehabilitation and long-stay care formed the major - if not exclusive - part of the work on all the other wards, with long-term care dominating. In looking after such patients, nursing staff become isolated from other health professionals whose energies are deployed elsewhere in curative and rehabilitative work; even though the doctors retain legal accountability for patients. But nurses too find curative and rehabilitative work rewarding: it is what they have been trained and socialised to do. Without instituting positive strategies to compensate for deprivation of this source of satisfaction on wards where patient care goals are primarily slow-stream rehabilitation and long-stay care, patients and nurses may undergo unnecessary unintended suffering. Even such comparatively minor strategies, like positive support and esteem for long-stay care-work emanating from consultants can, it seems, make the

difference between minimal warehousing and personal warehousing wards.

I would suggest that the meaning of 'care' needs to be clarified and that better-supported and properly-valued long-stay care-work might enable nursing staff to do their care-work in a far more positive, person-centred way which would feature explicit definition of patient care goals and care strategies. Graham (1983) discusses the shortcomings of available analyses of 'caring'. Psychologists emphasise caring - as feelings of concern and activities of 'tending' others - as a defining characteristic of femaleness. Sociologists emphasise the labour of caring, which is seen as being associated with women's subordination in a male-dominated society. A better understanding of 'caring', which involves both feelings and actions, can only emerge through an analysis which incorporates psychological and sociological perspectives, Graham argues.

So long as care-work is poorly understood and is seen as less important and rewarding than other kinds of work, it is unlikely that a move away from routinely-produced 'residual' care towards positively-defined individual care can take place.

Multi-disciplinary Teamwork: The Cornerstone of Good Geriatric Practice¹

Many British texts on geriatric medicine and the organisation of geriatric services lay considerable stress on multi-disciplinary teamwork as a pre-requisite for establishing and maintaining a good service. The excellence of the service is often construed in terms of patient turnover, inter alia, and little is usually said about what constitutes good

¹The discussion in this section is based on Evers 1981c and 1982.

practice and a good service when it comes to long-stay care. It is never made clear what teamwork is supposed to mean in terms of who team members are, the roles of team members, the process of team assessment and decision making, the accomplishment of team work with patients and accountability for patient care. It is widely assumed that teamwork is 'a good thing', yet the supposed benefits for patients remain rather obscure. For example Fairhurst (1977) analysed the content of supposedly patient-centred team discussions at case conferences, and found that the bulk of the discussions concerned the work of team members, requests for services, information and reporting back. The notion of teamwork, however ill-defined, is predicated on the assumption of a working consensus among the team members. This assumption seems dubious in the context of geriatric care, given the differing skills, power and status and priorities of the health professionals involved. Although at some level, all may share the general goal of serving the good of the patient, this is very abstract; and the preferred strategies of different team members are likely to vary. For example, the nurse may counsel caution in arranging the date of discharge, but the consultant may need a bed urgently. Very often, perhaps, differences in perspective or opinion may never be openly voiced because of the power differential between the consultant and the rest of the team members. Where does the patient figure? If s/he is to be a beneficiary, then there is a strong argument that s/he should be regarded as a member of the team, along with family members or other lay carers. In the eight study wards, staff seldom spontaneously included mention of the patient and relatives as members of the team, although when asked, they usually replied that patients and families should indeed be regarded as team members. At the same time, several nursing staff suggested that

relatives could sometimes constitute the staff's most serious source of problems. This could indicate that as outsiders, relatives have the potential to disrupt professionally-defined and initiated work strategies with patients.

I found that there was a semblance of teamwork, in the sense of collaboration of a company of equals under the leadership of the doctor, only for a tiny minority of patients: those whom I had categorised as rapid cure, and some of those categorised as for eventual discharge. These patients were agreed by all concerned to fit with the clinical-medical model of health care: crudely speaking, diagnosis of disease processes and application of efficacious treatment strategies with a view to cure, arrest or relief of the disease processes.

I have already said that for a majority of patients there was almost no regular contact with non-nursing health professionals. Where in effect only nurses are involved, there can in theory be a partnership between patient and nurse, but not a multi-disciplinary team. All the eventual discharge patients had some involvement with other health professionals. For some, the style of the professionals' work behaviour resembled teamwork as I noted above. But for the rest, multi-disciplinary work did not look much like teamwork. These patients by definition had not quite matched up, so far, to the 'ideal' of rapid cure and discharge. Very often there was a lack of professional consensus about appropriate strategies, where these were even discussed at all. In these circumstances, dissent might be voiced, and a 'solution' imposed, *faute de mieux*, by the consultant. Alternatively, decision making was avoided, and the tacit dissolution of the team took place. Neither patients nor relatives seemed always to be members of the team. Exceptions were Mrs. Brayfield at Shipton and Mr. Millward

at District. In both cases, there was consensus among the professional team members about patient management. This was positively endorsed in both cases by the patients and their families. The patients were both well-liked and their relatives were seen as caring and co-operative: they visited frequently and took an active but not interfering interest in progress. The patients' and relatives' opinions and convenience were explicitly taken account of in decisions about discharge and follow-up support at home.

The evidence from my study suggests that although the multi-disciplinary base and practice of geriatric care in hospital is stressed by the professionals, we cannot assume that it is a widespread feature of care management for a majority of patients. Furthermore, we cannot assume that undoubted benefits accrue for patients and their families, other than perhaps in the case of some of those patients who are viewed by the professionals as remediable and/or dischargeable.

Yet the professionals' emphasis on multi-disciplinary teamwork as central to the practice of geriatric care which is inextricably linked with the emphasis on effective cure-work, may be doing a disservice for the large number of patients who do not fit the models portrayed in the professional literature. To parallel the remarks of the preceding section of this chapter, better-supported, properly-valued care-work might facilitate a positive move away from the residual strategies which seem to emerge by default when rapid cure and eventual discharge goals do not quite fit the patients and nothing is clearly identified in their stead; and when multi-disciplinary teamwork fails to materialise, and no alternative philosophy and approach to defining and managing patient care is explicitly identified. Geriatric care is about a lot of other things besides cure, discharge and teamwork and, as the leading

accountable professionals in the arena, geriatricians would be doing a great service if the trend towards public discussion of these things were to be further developed. It is heartening to see, for example, some recent British texts on long-stay care initiated by doctors (e.g. Denham, 1983).

Gender and Geriatric Care

Among the study patients, women outnumbered men by more than two to one. This reflects the demographic structure of the elderly population. The vast majority of nurses, the largest professional group involved in caring for patients, are women. Although quite aware of these general features of geriatric hospital care at the outset, it did not seem a priori important to take explicit account of them in the research design. I did not imagine that gender - whether of patients or staff - would be very important in analysing patients' experiences and social relations in geriatric wards. As the research progressed, it occurred to me that I might be wrong. The evidence from my study suggests to me that gender is very important, the more so because to date British geriatric hospital services have completely ignored the possible implications of this factor for the organisation of services.

I discussed this topic, and some case studies of patients drawn from this research, in Evers (1981d). I will now summarise the main points of that discussion. First, I argued that the experience of patienthood differs for elderly men and women. Where illness and incapacity brings about dependency, the providers of care are generally women. Today's generations of elderly men have been accustomed to being cared for by women. For most of them, an important part of their status, identity and lifetime's accomplishment is derived from their

participation in paid work. This has enabled them to support their families financially, and may have brought other benefits - intrinsic satisfaction, social contacts - as well. They have reached and passed retirement: the ritual landmark that legitimises severance from perhaps a whole lifetime's occupation. Their workplace-derived identity remains more or less intact even when they become sick and dependent. For old women, things are generally a little different. While many of them have had paid work, on and off, it has generally been out of necessity, and fitted around their primary role as family carer. Except for the wealthy, old women have never been accustomed to being waited on or looked after. Thus to become a recipient of care represents a major discontinuity for a woman. Patients in geriatric wards may have experienced dependency on younger female kin, perhaps, or spouses, before coming into hospital. But elderly women may experience admission as confirmation that they are now incompetent with respect to their lifetime's involvement with care-work. Although of course, they may have lost many of the former family beneficiaries of their care-work, they have never formally 'retired' from their occupation of a lifetime.

What of the nurses? Geriatric nursing, as portrayed in my study as well as others, features a high proportion of what has been described as 'basic' - as opposed to technical care-work. As McFarlane (1976) pointed out, it is tragic but nevertheless true that 'basic' work has come to be seen as humdrum, professionally uninteresting and unskilled. It is highly concrete and visible. As such it is eminently routinisable and easily open to rigid hierarchical control. In doing geriatric nursing, the nurse must handle various tensions associated

with these features of the work and with the patients they care for. First, 'basic' care-work in nursing involves many of the activities done unpaid by all women who nurture others, usually family members. Yet nurses are 'professionals', and when providing basic care for women patients who are also experts in this work, there is a potential challenge to the professional status of the nurse. Second, there is the conflict between giving expression to the true 'caring role' of the nurse (Norton, 1965) and achieving concrete and administrative task goals which satisfy hierarchical control requirements. In order to achieve the latter, it may sometimes be necessary for nurses to render patients subject to hierarchical control, e.g. by treating them as work objects. Third, there may also be tensions associated with the personal and professional aims of doing good care-work for people who might be viewed as equivalent to a grandparent or parent. The thought of these kin requiring feeding or worse, changing and toileting - akin to the needs of a child yet in an old person unacceptable, undignified and perhaps irremediable - may be abhorrent. Fourth, for predominantly female nurses caring for a female-dominated patient population, there is the constant reminder to the nurse of her own future possibilities. Parallel stresses may of course arise vis à vis old men; but identification with patients of the opposite sex may be less close, and the demographic position on differential survival rates between the sexes is only too well-known.

To develop the analysis further, I will summarise my 1981 discussion of three types of women patients. These stereotypes are strategic rather than representative, chosen to illustrate the importance of gender order in influencing patients' experiences in the hospital ward.

Type One: Dear old Gran

A minority of patients were of this type. They were all popular patients, and tended to be cheerful and appreciative of the nurses. They were capable of sustaining mutually satisfying social exchanges with staff. They fitted in with the ward's routines and were usually undemanding and uncomplaining. Most of the Grans seemed mentally alert most of the time; but some had spells of confusion yet remained cheerful and able to engage in positive though perhaps not meaningful conversations. Some were very dependent, others much less so. They complied with staff-initiated routines, and surrendered their autonomy to the professionals. These patients got more than their share of any 'treats' which materialised on the ward - a particularly nice dress, perhaps - and any demands which they made outside of the routine were usually treated with indulgence. These were 'good' patients who, through fitting in with the nurses, were consciously or unconsciously making the best of the circumstances of dependency in which they found themselves. The nurses seemed to speak of them and treat them like indulged children. These patients' experiences always tended to look like personalised warehousing. Other researchers too, e.g. Paterson (1977) have noted the tendency of staff to treat elderly patients like children.

There were men who seemed equivalent to the Grans: but there was an important difference. The personality and individuality ascribed to the patient by staff was often inextricably bound up with his life history. His pre-retirement work was usually known and talked of, together with other aspects of his past life. It seemed that far less was usually known by nurses about the biographies of Grans, and many of the female patients. I suggested in 1981 that perhaps it was less important to nurses to know the biographies of their women patients who were, after all, 'only'

housewives and redundant ones at that. Thus perhaps fewer conflicts presented themselves to nurses faced with the requirements to control and manage their patients: patients who seemed to enjoy less than adult status.

Type Two: Poor Old Nellie

This type of patient was more common than Dear Old Gran in most of the wards, apart from District and Heathlands. All such patients were 'senile' or 'confused' (though not all senile or confused patients were Nellies: some were Grans) and all were markedly dependent on nursing staff to help with basic living activities. Most of these patients seemed neither especially popular nor unpopular. They all fitted into the routines, indeed, the routines seemed to be built around patients such as these. They were seldom capable of sustaining an apparently mutually rewarding social exchange with staff. Most of the heaviest work came from these patients, but was tolerated by staff who seemed to regard such patients not as sweet children like the Grans, but as unfortunate children; objects to be pitied. Despite the workload associated with many of these patients, they offered no real problems to the staff. Any 'difficult' behaviour - for example noisiness or wandering - could often be contained or controlled by the use of medication or physical restraint in a geriatric chair.

There were also men patients of this type, whose experiences were very similar to the women. The difference was, as with the preceding type of patient, that the biographies of the women were less often known than was the case with the men; and the women were more likely to be spoken of as though they were 'non-persons'.

Type Three: Awkward Alice

There was a minority of this type of patient. All were mentally alert all or most of the time. All were articulate, and each asserted her individuality when this was challenged by the way the ward's routines operated; for example refusing to eat the fifth salad meal in five days when the hospital had deemed a reducing diet to be necessary, and demanding an alternative. Awkward Alices expressed gratitude to the nurses when they judged this to be deserved; their praises were not indiscriminate. Some of the time they were cheerful and good company, but, if suffering or otherwise in need, they would make their wishes known in no uncertain terms, and would press their requests if no 'reasonable' cause for delay was evident or explained to them. They sometimes criticised staff, e.g. the way nurses went about their care-work (helping patients with washing, dressing, feeding, getting to the toilet) - and they, after all, being women, were experts on the nature of 'good' care-work - the lack of freedoms and privacy afforded by the regime; and difficulties of access to doctors and remedial therapists. They varied in their dependency on nurses; some were heavily dependent, others virtually autonomous with respect to carrying out the basic functions of life. All Awkward Alices had a hard time, and caused the nurses control problems, and sometimes care problems as well. They were seen as 'difficult' patients for although they all seemed prepared to respect the professionals' judgments about their care needs to some extent, they were certainly not willing to hand over their autonomy in its entirety to the professionals. Some patients consciously resisted hierarchical control, others challenged it unwittingly, through their attempts at self-preservation. Alice Larkin, a strategic patient at Moorhouse (see p.164) was one such patient. Once 'labelled' as an Awkward Alice, redefinition was difficult. Patients' conscious efforts to collaborate with staff-

initiated programmes were greeted with suspicion: "What's she up to now?" Because these patients were both mentally alert and articulate, control strategies such as medication and physical restraint were less easy to apply. Other tactics were brought to bear: isolating patients in side-wards, leaving them till last (for baths, dressings etc.) and making it plain; 'threatening' them with The Doctor; ignoring them, chastising them in public. There were men patients equivalent to the Awkward Alices. They offered a qualitatively different critique of nursing work, though. Not being 'experts' on basic care work as are women patients, the men's criticisms seemed to be more global. Nurses seemed to have more difficulty in controlling these men patients, who would - often successfully - enlist other people to do their bidding, or simply shout. This was quite effective: shouting poses a threat to nurses' professional and hierarchical control of the ward; and as Rosenthal et al (1980) suggested, a stereotypical view of men as 'naturally' assertive may render responding to men patients' 'excessive' and vocal demands more acceptable to the nurses than would be the equivalent response to a 'demanding' female patient.

Another difference between Awkward Alice and her male equivalent was, as with the other types of female patient, that the details of her personal biography were less well-known; she tended to be de-personalised to a greater extent than her male equivalent.

Why should the identity of women patients apparently be less visible and regarded as less important than that of men patients? In 1981, I argued that this reflected prevailing gender divisions in society: men's work is public and visible; women's work in the home is private, unremarked

unremarkable. It is only relatively recently that social science has begun to address the divisions between the 'public domain' and the 'private domain'. Margaret Stacey's (1981) analysis shows that the major categories of social science relate to institutions of the public domain which, of course, includes the (paid) workplace. These categories are inappropriate for analysis of the social relations of the private domain. New concepts must be developed to analyse the latter, and to transcend the divisions between the public and the private; the worlds of paid and unpaid work. On a more concrete level, experiencing dependency as a patient may be more demeaning for the mentally alert when they are divorced from their own biographies. For nurses, who especially in geriatrics, are paid, professionalised performers of 'women's work' in relation to people who are themselves 'experts' in this kind of work - women patients - the challenge to their own status may the better be denied by depersonalising the objects of their professional ministrations. Nursing men patients does not pose a threat to the nurses' ownership of care-work but reinforces it. Divorcing women patients from their own biographies perhaps resolves various conflicts for nurses, and helps assure their success in organisational-bureaucratic terms as care givers to, and controllers of their patients, although some patients - the Awkward Alices - pose continuing problems. This is not to say that men patients therefore have a 'better' experience of hospitalisation: for them there may be qualitatively different problems, e.g. being labelled as 'dirty old men'. Patients' sexuality seems a subject which is totally denied in the geriatric hospital setting, other than as a matter for scorn or jokes.

This analysis may well be peculiar to the present generation of old people. The possibility of changes in the division of labour in the family, and alterations to the characteristics of gender order in society may result in a different set of contingencies for future generations of geriatric patients and the nurses who look after them. But, in the meantime, the problem is to do with designing hospital regimes which both preserve the identities of patients, particularly perhaps the women (although the problems for men of living in such a feminised environment also require analysis and thought, as noted by Willcocks, 1982) without exacerbating the tensions experienced by nurses which evoke control strategies of dubious benefit to either nurses or patients in the long run. Offering greater opportunities for patients' autonomy - freedom to continue with the lifetime's skills in carework for themselves or other members of the 'community'; to pursue personal interest or hobbies - seems an obviously constructive goal in this context. But the experience at Heathlands indicated how hard it is for all concerned to begin to make inroads here. Greater autonomy for patients means greater uncertainty, unpredictability and complexity for staff, and fewer opportunities for retreat into strategies for depersonalising patients and routinising work solely for convenience sake.

The preceding discussion about the relevance of gender to understanding social relations in geriatric wards is not based on rigorously-collected data, because I had not incorporated this into the research design at the outset. But this section of the thesis can be justified on the grounds that this factor emerged as important; that it has been neglected in other analyses, with one or two exceptions, e.g. Willcocks (1982), and by professional workers with elderly patients in the U.K. It is a topic which should be subjected to systematic analysis in the future, with a view to informing policy and professional reviews of models for institutional care provision.

Conclusion

This chapter has offered some explanations of the findings that geriatric care in the eight study wards failed in many respects to match up to public and professional policies. I have also commented on some reasons why policy is less than forthright when it comes to long-stay care. The contrasts between the minimal and personal-warehousing wards suggest some concrete strategies which might be taken up in an attempt to reduce the incidence of minimal warehousing. In all the wards however, the findings regarding patient care goals, multi-disciplinary teamwork and gender as they affect patient care practices strongly suggest that a radically different model of care is called for. In the final chapter, I will take up this issue.

CHAPTER EIGHT

TOWARDS A POSITIVE MODEL OF CARE

The aim of this chapter is to be cheerful. The central theme is that there are practical possibilities with respect to developing new and more positive care practices for elderly people who might find themselves within the ambit of geriatric services. I shall divide the chapter into three sections, as follows:

1. Evidence of humane treatment in geriatric care
2. My conclusions and recommendations: towards a more humane care system
3. Practical developments: wider applicability of indices of inhumane treatment

Humane Treatment in Geriatric Care

What constitutes humane care? And how is it to be achieved? I feel there is no definitive answer to these questions at present. As I noted in Chapter 2, no attempts to devise measures of quality of patient care altogether succeed in resolving the intractable problems of establishing professional and sociological definitions of good quality of care for patients in hospital, and of concrete indices of quality. And there is scant evidence that improvements in patient care have ever resulted directly from using 'measures' of care standards or prescriptions for patient care such as the British Geriatrics Society and Royal College of Nursing Checklist (1975). An analytically constructive - as well as far less daunting - approach is to identify indices of bad practice or inhumane treatment about which there is likely to be professional and sociological consensus; which is what I have done in this study. Absence of inhumane treatment of the kinds

identified in my study is a prerequisite to positive quality of life. Although a necessary condition for quality of life, absence of inhumane treatment by itself is not a sufficient condition: something more is needed. To elaborate on what this 'something' might consist of, I will review some observational data on positive departures from 'normal' practices.

In the last chapter, I noted that there were some patients, for whom the care goal was rapid cure and discharge, whose experiences of multi-disciplinary teamwork were very positive. There was consensus among the professional workers as to patient management; the patients and relatives also concurred with the professionals' views and strategies; and the patients actually achieved what was expected of them. Patients, relatives and staff all seemed to find this a gratifying experience; what the best of geriatric care is all about. I also noted that this applied only to a minority of study patients: those who came closest to being 'ideal' patients in terms of their cure and rapid turnover potential. But most patients are not ideal in this sense, and care for non-ideal patients tends to emerge de facto from catch-all routines rather than from any very positive strategies. In the second part of this chapter, I shall argue that a reconceptualisation of patients, embodied in changed work practices, is needed in a more generally positive model of care.

I am happy to say that although the picture this research has so far painted is a rather gloomy one, there were in fact numerous instances of what I felt were attempts to provide good quality care in the senses that (a) inhumane treatment was not apparent and (b) the care was what I myself would have been happy with had I been the patient on the receiving

end and (c) that the patients actually on the receiving end, insofar as they seemed capable of doing so, evidenced positive affect.

At Cranford, the occupational therapy aide organised weekly cookery mornings in the Activities Room on the ward. Patients from a second geriatric ward joined in, usually about twelve patients in all participated. Besides participating with obvious enthusiasm in the production of teatime goodies, these sessions were occasions for social intercourse among patients, for reminiscing and sharing a joke.

A group of schoolchildren visited Cranford regularly, and generally spent time talking with the patients. These conversations seemed to be enjoyed by both parties: the children and patients alike were interested in the contrasts between their respective youthful experiences. Heathlands, too, had voluntary visitors from a local school, who joined enthusiastically in games of scrabble with patients, making Christmas decorations together, or simply talking. These examples were adjuncts to the ward regime initiated and sustained by outsiders.

Arranging various kinds of events was part of life at Heathlands. During the research there was the ward's bonfire party - a feat of considerable organisation on the part of some of the staff, but an event which seemed to be greatly enjoyed by almost everyone who participated. At Norton, a study patient's daughter - Miss Wood - came each evening to put her mother to bed and give her her supper. Not only did she care for her mother, she also helped other patients. She knew them well, as she had been visiting the ward for a long time.

One of the study patients at Norton was blind, and because of this and the nature of the ward's routines, she suffered considerable difficulties with summoning assistance when she needed it, with getting about, and with being treated as though she was deaf and senile as well as blind. One of the nursing auxiliaries on this ward provided this patient with personalised care - despite the routines - which was greatly appreciated by the patient. She always consulted the patient about which clothes she wished to wear, including details of colour schemes. She allowed Mrs. Walpole the time to perform her own basic care activities, which other nurses seemed to assume she was incapable of; as she walked with Mrs. Walpole to the toilet or day room, she described the landmarks and their progress as they went along; and she always explained to the patient, if she was needed elsewhere, the reason she was going and when she would be back to help complete the tasks she had been carrying out with or for Mrs. Walpole. Not only was this nurse auxiliary providing personal care, she was also encouraging the patient to make her own preferences explicit, and to discover her own ways of coping with her handicap. This auxiliary was not popular among the staff. She was generally viewed as unreliable, too slow and not pulling her weight.

This was also true of an auxiliary nurse at Eastwood. He was a school leaver waiting to begin a university course. He came in for censure from most of the other ward staff for being slow and not doing his share of the work. He was inclined to stop and have conversations with the patients he was working with. He would stop to hear the answer, and perhaps discuss it, following the almost ritual question "And how are you today?" He was also said to be 'soft': he would usually respond immediately if a patient asked to be taken to the toilet, even if he was

in the middle of doing something else, e.g. serving meals. 'Soft' was an epithet applied to another, permanent, auxiliary on this ward. She too would talk to patients at their own time, and 'indulge' their requests for help or 'favours', e.g. fetching their pipes and tobacco. But she was never criticised for not pulling her weight: instead she was sometimes told she should not be doing so much. She tended to look after the least popular and heaviest of the ward's patients, and she would almost never leave the ward until well after her shift had officially finished.

On all the personal-warehousing wards, there was some evidence of study patients being cared for sensitively and considerately by some of the nurses from time to time. The three examples of deviant nursing auxiliaries and of 'outsiders' - occupational therapy aide, schoolchildren and patient's daughter - illustrate how positive contributions to care of elderly patients come about despite rather than because of prevailing ward philosophies and practices. In all cases, the essence of it involved creating a social situation in which patients were enabled to determine their own responses to their needs of the moment. And therein lies the germ of what is required of a new model of care: philosophy, practice and organisation which will facilitate the emergence and the primacy of patients' own perspectives on their problems and possible solutions to them to the extent that their medical, physical and mental functional state allows. Safeguards - to be discussed below - are needed to ensure that basic human dignity is always respected for those patients whose personal capacity for preserving their own dignity is significantly impaired.

My conclusions and recommendations: towards a more humane care system

As I noted in Chapters 2 and 3, there is no prospect of agreement about what constitutes quality care in the round, how to recognise it, how to organise care settings so as to achieve it and how to assess what has been achieved through organisational development. That was why I opted for grounding my analysis in the systematic documentation of inhumane treatment, which is far easier to recognise and agree about.

There is a wealth of research-based, professional and policy-related literature offering more or less general statements about the principles which should find expression in the provision of institutional care for elderly people. Because they are so general, and stated at a high level of abstraction, they may be widely agreed on by interested parties - but probably for widely differing reasons. As such, they are not necessarily all that helpful when it comes to considering actual practice. An example is primacy of a person-centred approach advocated by proponents of "Nursing Process". There are also examples of highly specific and concrete guidelines, some of which I cannot imagine anyone from our culture disagreeing with. For example that people should wear their own clothes and that everyone should be afforded privacy when going to the toilet. Concrete guidelines by themselves do not tell us about the fundamental obstacles to be challenged, nor how to challenge them, in rectifying continuing and prevalent inattention to basic human rights. In this section of the chapter I shall turn to the question of how to secure humane care in practice.

Improve the Status of Old People and Reform the State Service System

Wade et al (1983) and others call for what amounts to a revolution. Society should 'revalue' the old and change the labour market and service infrastructure in furtherance of this end. At its broadest level, as

Townsend (1981) and Walker (1980), also Phillipson (1982) have argued, the dependent and subordinate status of the old is reinforced and even created by the operation of our social institutions. In the context of today's taken-for-granted expectations about standards of living, the majority of the old are relatively deprived; through having been ejected from the labour market without any choice in the matter. Thus their access to resources is restricted by reduced income, at the very time in life when new material needs may emerge: extra heating, special diet, taxis because buses can no longer be used, adaptations to the home, and so on. Walker (1983) is among those who argue that family carers for old people - predominantly the women of the family - also become locked into social institutions which reinforce their dependence. Government policy indicates that the family should - and the evidence is that it does - provide the major part of care needed by old people. Yet carers are often denied the economic and service support to help them in doing this. For example only men and single women who give up work to look after an elderly relative are entitled to receive the invalid care allowance; and usual workplace arrangements allow of no concessions in support of people of either sex who look after the old. This is not only discriminatory but counterproductive. Better provision in these two areas - and others - could prevent or put off breakdown in informal care arrangements, saving the use of expensive hospital beds. (Admittedly it would be extremely difficult to demonstrate this empirically, but the Kent Community Care study has generated some findings which would support this: Challis and Davies, 1980). These commonsense measures have been widely called for over a number of years. One reason why they fail to materialise goes beyond consideration of cost. By reason of historical-political development, institutionalised obligations towards and costs of elderly people are split among various separately-organised and

financed public bodies: the NHS and the various tentacles of local government-administered services e.g. housing, social services; and, separate again, the social security system which handles pensions and cash benefits. The last is a minefield of complexity and anomaly. Health and welfare organisation tends to appear more concerned about such issues as negotiation and maintenance of boundaries than about the clients in whose service lies its supposed *raison d'etre*.

In short, what is needed is to call into question the whole arena of public policy in the U.K. for the old and their families such that people and their needs and resources are the central consideration, rather than problems of how to fit old people into bureaucratically- and/or professionally-defined categories. These are often incongruent with the way old people and their carers view the needs of the moment. So far as hospital care goes, the tensions over relative responsibilities of general, psychiatric, geriatric NHS hospitals and primary care workers; social services and housing departments, should be addressed through reconsidering the organisational boundaries themselves; in the context of a proper understanding of the needs of old people.

This kind of argument is of course regularly and frequently advanced; and, although totally unrealistic, it is no bad thing to remind ourselves of radical reforms we might aspire to. But there are some more immediate and practical steps which can be suggested drawing on the data and analysis of the small-scale study described in this thesis.

Principles of and options for humane care given various constraints

I have already drawn attention to the basic principles which need to be translated into practice, on p.285. That is to say, old people should always be the subjects and not the objects of care strategies which are

designed, in relation to the unique care goals - defined jointly and kept under review by patients, professional and lay carers - established for each individual. It naturally follows from this that basic human rights to respect for personal dignity will be safeguarded. This kind of statement is fairly abstract and probably quite uncontroversial. Baker (1978) and others make similar remarks. The findings reported in my thesis suggest some concrete options in pursuit of the general principles. All are interrelated.

First, the different patient care goals categories - acute/discharge; medium term rehabilitation/discharge; long-term care and 'good' death (discussed in Chapter 7) - and the broad strategies which flow from these should be explicitly defined and recognised as of routine. Care-goals should be identified in collaboration with each patient and regularly reviewed by the prime accountable carers and other patient care workers. There should be fail-safe routines to accomplish basic care across the board, in a humane and dignified fashion. In parallel with these, there should be flexibility in selection from a repertoire of general care strategies related to the different general types of care goal, and adapting these to individual patients' needs.

Second, the prime accountable professionals should self-consciously adopt highly visible work practices which recognise that very different kinds of cure-work and care-work are called for with different patients and which embody equal respect for the worth of all categories of elderly patient. On the personal warehousing wards in my research, there was evidence that the consultants, as prime accountable professionals, recognised the value and validity of care-work in association with long-stay patients. Their work practices reflected this in different ways.

At Cranford, Dr. Pyne devoted time on each of his ward rounds to the long-stay patients. At Shipton, Dr. Livingstone and Dr. Burton informally but explicitly delegated prime responsibility for care-work with long-stay patients to the nursing staff, relying on them to judge whether and when medical opinion or intervention should be sought. At Heathlands, Dr. Burton had wanted to go further, and hold 'surgery' sessions which patients would choose to attend, rather than the traditional ward rounds. This approach might usefully be tested in a hospital setting offering rather more support than Heathlands received for its new approaches. It is but a small step further to ask whether doctors should in all cases be the prime professional carers for long-stay patients.

My third concrete suggestion in search of more humane care is that all geriatric departments should seriously and explicitly consider the question of who the most appropriate prime accountable professionals should be in relation to the rich variety of patient types with which most geriatric departments are concerned. From my own study, I should really restrict my comments to long-stay patients. In this study, the prime carers were often in practice nurses. Evidence from other studies (Wade et al, 1983, Dodd et al., 1980) shows that people in long-stay geriatric wards do not form a distinct population as compared with the inhabitants of residential homes, and even sheltered and ordinary housing, where doctors are obviously not the prime accountable carers. Thus, I would argue that serious consideration should be given to whether in the NHS hospital setting nurses should not formally be made accountable for the care of long-stay patients. This would improve the status of long-stay geriatric nursing vis-à-vis other nursing specialties, provided that certain other changes were effected in support of this. If a new type of ghetto for patients and staff is

to be avoided, both need to have ready and priority access to the skills of other professionals as of right, and regular, joint, patient-centred reviews would be needed. Nurses' command of the necessary resources would need to be improved, e.g. appropriate and ample equipment, a reasonable environment and, within broad NHS norms, equitable staffing levels.

For this to come about, nurses' accountability for long-stay care at ward level would need to be supported by powerful and informed nurse management up to the highest levels; organisationally and professionally placed to command the backing of the medical profession in its efforts to improve the organisation and practice of geriatric, and particularly long-stay nursing care. An alliance between the geriatric long-stay care specialty, and other long-stay care workers, e.g. in mental illness and handicap and younger chronic sick, might prove mutually advantageous in establishing the status and legitimacy of long-stay care-work, and command over scarce resources, and would broaden the authority base of geriatric nurses beyond the bounds of the medically-defined specialty.

The DHSS is currently researching the feasibility of establishing nurse-controlled long-stay nursing homes within the NHS (Bond, 1983). Developments on this front should be watched with interest. With more than half an eye to the experience of North America, some would argue that long-stay care should not be removed from the medical ambit since no safeguards are sufficient to assure that inhumane care does not become the norm. Further, there is always the danger that introducing yet another type of care facility into our already complicated array will do no

more than represent another staging post for the dependent old person whom professional workers wish to move on from their territory.

Because the whole context of long-term care is so different in North America, I think we should be cautious about extrapolating.

But whichever is the prime accountable profession, my fourth suggestion concerns educational steps which might be taken towards destroying the 'poor relation' practice and image of care - as opposed to cure-orientated services, and improving the status and humanity of work with elderly patients, particularly long-stay patients. A reorientation of basic and post-basic nurse education is needed. Proponents of the 'nursing process' might argue that this has already begun, and that medical-curative domination of nurse education and practice, to the detriment of patient-centred nursing care, is now being successfully challenged. Education of all other health care professionals, most important of all, doctors, should challenge the negative stereotypes of work with old people, and, most negative of all, long-stay elderly patients. Isaacs (1984) gives an account of his own very positive approach to teaching medical students about the geriatric specialty.

Irrespective of who the prime accountable carers are, my fifth specific suggestion is that open organisational boundaries are vital. Earlier in this chapter, I noted that volunteers seem to have an important contribution to make, and the positive involvement of as many other people as possible - relatives, Community Health Council members, community health and social workers, other old people living nearby - can potentially enrich the lives of long-stay patients and the nurses who look after them, as well as helping to keep all concerned in touch with the world outside the hospital. This is very important in preventing the

evolution of grotesque routines and practices which can so frighteningly easily become the norm in institutions which are effectively divorced from their environments, as evidenced in some of the Hospital Inquiry reports, discussed in Chapter 2. The organisational boundaries should be routinely breached. Geriatricians often argue that community orientation is a distinctive and valuable feature of their medical specialty (e.g. Harrison, 1984), yet other workers in the specialty tend not to work outside the hospital, particularly not the nursing staff. There should be far more interchange between community-based and hospital-based professions than is currently the case. This too would help keep the hospital nurses' feet firmly on the ground, while enormously facilitating more sensitive appraisal of the strengths and problems of those old people who happen to become long-stay patients. Neither should patients remain prisoners in their hospitals, as I noted earlier.

My sixth concrete suggestion is that internal as well as external boundaries should be scrutinised. A fresh look should be taken at the perennial question in the geriatric specialty as to whether different categories of patients - acute, rehabilitation, long-stay, so-called - should be segregated or integrated in geriatric departments.¹ The argument for mixing different types of patient turns on the supposed benefits for nurses - and thus it is assumed for patients - of enjoying the challenge of nursing at least some acute patients who get better and go home. This supposedly lessens the 'burden' of long-stay care-work, which the nurses then perform to a higher standard because their morale is better (Harrison,

¹ There are related and more fundamental questions regarding the organisation of the geriatric specialty as a whole; for example, whether geriatrics and general medicine should be more strongly integrated and, if so, what forms this integration might take. I have reviewed some of the arguments which geriatricians have advanced in Evers (forthcoming).

1984). But my research tends to suggest that although wards are supposedly geared to caring for patients with a variety of needs and projected lengths of stay in hospital, in practice their routines are narrowly geared to 'producing' care deemed appropriate to a particular category of patient. For example, District Ward was pretty good at 'doing' cure-work with 'ideal' patients who fitted their discharge-oriented work philosophy and practice (Harry Willis discussed in Chapter 6, p.203) and their secondary routines were geared to a few inherited longstanding long-stay patients. But patients who did not fall into either of these categories and could not be made to fit, suffered inhumane treatment; for example Costa Makris. At Heathlands, which had many positive features in its regime, which was geared to 'doing' long-stay care, again, patients who did not fit in suffered inhumane treatment. Thus the issue of segregation or integration can be re-stated putting the patient at the centre of the argument. The choices seem to be (a) to do one type of geriatric care very well, and to carefully select out any patients who do not fit either at the outset, or through transfer; or (b), which could organisationally find expression in various ways, is to choose to do a variety of types of geriatric care very well, and to be able to discriminate which of a variety of general approaches should be adopted and adapted to particular patients' needs. Both (a) and (b) are predicated on explicit assessment of care goals at all stages from pre-admission on. That old people are not parcels to be delivered to the appropriate sorting office is recognised in (b).

None of the wards in my study showed great variety in its repertoire of routines, nor flexibility in their application: Heathlands probably came the closest to showing some variety, notably, conscious efforts to preserve patients' rights to autonomy; freedom of choice. But even Heathlands wasn't all that flexible - vis à vis the case of Thomas Westland

who suffered inhumane treatment because he could not be successfully rehabilitated. A part of the problem was lack of explicit awareness of individual patient care goals coupled with confusion about who the prime accountable carers were in practice.¹

If narrow repertoires of practice are commonplace in geriatric wards, the evidence of the inhumane treatment experienced by 'misfit' patients in my research suggests that separating the long-stay patients out might improve their chances of receiving humane care. Preconditions for any resultant improvement would be concurrent organisational, educational and practice changes aimed towards improving the status and the practice of care-work. Interchange of nurses between wards might also prove constructive.

My seventh suggestion is that the impact of gender on patterns of care provision should be reviewed, and consideration given to ways of recognising and meeting the distinctive needs of women and men as patients. As a prerequisite, care providers and their managers need to be alerted to this issue as being one of great relevance. I have not found any professional literature on the implications of geriatric care as a female-populated specialty and probably few professionals have given much thought to this. Guiding principles, it seems to me, are facilitating patients' exercise of autonomy in sustaining those habits and interests closest to the maintenance of their very identity. Obviously this means different things for different people. At its most basic, for many women, the chance to prepare a cup of tea with or for their visitors might be important; as also might be helping in the choice and care of their own wardrobe (not that many geriatric

¹In Evers (forthcoming), I discuss the paucity of evidence that 'Nursing Process' is as yet solving problems like this.

patients have their own clothes). In mixed wards, both sexes probably appreciate the chance to choose whether and when to pass their days in the company of their own sex, or to mix. Sharing a drink together is probably a widespread masculine habit among the current generation of old people, so why not allow this to happen in or from the hospital. Other examples could be given. None of the wards in my study showed any signs of recognising the differential needs of men and women patients, and autonomy to do ordinary 'womanly' or 'manly' things was totally lacking. As I argued in Chapter 7, there was evidence that men and women patients may well have distinct kinds of experience and treatment in hospital.

My eighth suggestion is that gender and the nature of care-work must be carefully considered in relation to nursing staff. Traditional women's (unpaid) work in the home is in the hospital carried out by paid, professional workers. As I argued in Chapter 7, this poses many largely unrecognised conflicts for nurses as well as patients. Nurses in long-stay care enjoy low status, work very hard, often have unsocial hours of duty, and are not particularly well paid to say the least. Humane care for patients probably cannot be provided by paid workers who are not themselves greatly cared for, and whose work is not particularly well regarded. This issue therefore crosscuts all the others.

At best, the lynchpin workers - the nurses - should be properly recompensed for their difficult and demanding work. (The geriatric lead, extra payment for working in the specialty, amounts to under £200 p.a. at 1984 rates). Adequate numbers of staff should be available to obviate the experience of physical exhaustion ~~as~~ of routine, and allow greater flexibility for staff to respond to changing needs of their own families. Opportunities for training should be enhanced, as

well as other types of job enrichment: the opportunity to practise continuity of care through crossing institutional boundaries to work in other settings, for example. The whole gamut of under-resourcing in the specialty should be tackled. Little of this, of course, is likely to happen in the foreseeable future, as it would prove extremely costly.

So within current constraints (which we should always be reluctant to accept as given) what could be done? More widespread and explicit recognition of the emotional as well as physical challenge of geriatric nursing work is needed. This could take expression in various ways, local trial and error being important in discovering a constructive approach. Counselling, multi-disciplinary support groups, stronger nurse management not perpetually involved in 'fire-fighting' over minimal staffing levels, closer integration between nurse management and nurse education in relation to ward-level practice, more widespread involvement of family carers and volunteers - probably with specific nurses designated to co-ordinate and monitor, as this could otherwise prove a source of added work and stress under some circumstances; are all potentially testable ideas here. Not only is it important for the nurses to try out new ways of providing the support they probably need, it is also important for patients. Nurses who are well cared for may themselves provide more humane care for patients: that is an empirical question. But in my research, I repeatedly noticed that nurses under pressure were a cause of great concern to at least some of the patients. Bearing in mind that 'busyness' may sometimes be used as part of a strategy for controlling patients' demands, there were times when patients would remark on the nurses' seeming overworked, and feeling sorry for them and also reluctant to voice their own (sometimes very pressing) wants which would add to the workload. It seems invidious that patients should feel

guilty about being patients, on account of the work they might be making for those who are paid to do this work. The long history of 'the nursing problem' may have a lot to do with the perpetuation of the bad image of all institutional care for old people, as Finch and Groves (1983) point out. Even if revolutionary changes are currently out of the question, there is much that could and should be done to improve the lot of the carers.

Towards a more humane care system: Summary of suggestions

1. Variation in patient care goal categories, and the different work strategies which flow from them, should be explicitly recognised; and individual care goals should be defined and reviewed in collaboration with patients and their relatives.
2. Review, and modify if necessary, the work practices of the prime accountable carers so as to embody equal respect for all categories of old people, including those who are or who become long-stay patients.
3. Review the question of who the prime accountable carers should be: there may be a case for legitimating the nurses' custom-and-practice position as prime carers for long-stay patients. The danger of instituting a new form of ghetto for patients and nurses would need to be confronted through assuring nurses' and patients' access to resources, including the skills of other professional workers. Stronger nurse management might help here. (See also 5 below).
4. Whoever the prime accountable carers are, the status and practice of geriatric care-work could be enhanced through changed approaches to education of nurses, doctors and others.

5. Whatever the nature of internal organisation, open organisational boundaries are vital. Outsiders should be encouraged to come in and to participate; and insiders - patients and staff - should have the right and the opportunity to go out; the latter to effect more continuity in the care of those of their patients who go home; and as a safeguard from becoming locked into inhumane institutional norms.

6. The arguments for and against segregation or integration of different types of geriatric patient with geriatric wards should be reviewed, placing the patient at the centre of the debate. The evidence from my research shows the study wards had narrow repertoires of practice, and patients who did not fit these experienced inhumane treatment. If this is a prevalent feature in geriatrics, then separating the long-stay patients out might improve their chances of receiving humane care, given concurrent organisational and practice changes aimed towards improving the status and the provision of care-work.

7. Workers in geriatrics should be alerted to gender-related issues arising in relation to how patients are construed and managed and how patients themselves experience hospital care. Ways of enabling distinctive needs of women and men patients to be met must be thought about, and, however little change may currently be practicable, new approaches should be tried.

8. The 'women's work' of geriatric nurses needs to be properly understood and properly valued. Even within rigid resource constraints, there are various avenues worth exploring for their potential to generate some care and support for nurses as lynchpin workers in geriatrics.

Establishing a means of securing feedback about the impact of attempts to effect changes in policies and practices may facilitate informed and compassionate development. Following on from my research, the idea of using indices of inhumane treatment has great potential as a method for professionals to monitor what they are doing and to develop their ideas. In addition, involving patients and relatives in using and acting on indices of inhumane treatment could contribute to establishing and maintaining a climate of openness. This is so vital for ensuring that distorted and dehumanising practice norms do not emerge (Stacey, 1984). The next and final section of the chapter will elaborate on these points.

Practical Developments: Wider Applicability of Indices of Inhumane Treatment

In my research, I have tried to synthesise ideas from sociological analyses of institutions, particularly institutions which care for elderly people, current policies and analyses which have emerged from inquests into a variety of institutional atrocities. This led me to the notion of inhumane treatment, and the possibilities for its systematic, non-emotive analysis.

This piece of research, small-scale though it was, has I feel demonstrated the potential of this kind of analysis to generate a systematic picture of patients' experiences in geriatric wards. At the same time, the approach has enabled a positive move forward with respect to outlining some practical steps towards a better future.

It is customary for the final chapter of a thesis to call for further research. Although my research clearly does not represent the definitive study of the problems of geriatric care, the kind of

research which I would now want to suggest concerns further development of the potential of the inhumane treatment index. It could be of widespread practical use to professionals in monitoring the impact of their practice on patients and in ensuring that humane treatment becomes the norm in their own departments.

The constituents of my indices of inhumane treatment derived from principles of 'do as you would be done by' and from patients' own reactions to their experiences, as construed by a person who was a social researcher and not a professional, lay or patient participant. Types and examples of inhumane treatment are given on p.66, Chapter 3. Briefly, primary inhumane treatment was suffering which could be directly attributed to the fact of the patient being in hospital. Secondary inhumane treatment featured failure of staff to respond to patients' distress which was not directly attributable to the experiences of being in hospital, for example distress arising from illness. Tertiary inhumane treatment featured discussion about or planning for the patient, in the patient's absence, which seemed to regard the patient as a work object, and excluded her/him from the decision process. My general approach might be adapted to generate a quantitatively-based analysis (see Chapter 7, p.244). It could also be extended in various ways; for example to include observation of incompetent and inhumane professional practice and its antecedents, and from that, to develop an analysis of how to go about assuring the converse. Before an inhumanity index could be used to improve practice, it would need to be developed and tested - perhaps through action research - in order to establish its validity and reliability.

How would use of an index work in practice? I am not proposing some kind of extension to the Health Advisory Service 'inspectorial' function, and it must be acknowledged at once that the practicalities would not be all that easy. For example, a climate would need to be created

in which review of inhumane treatment would be experienced as constructive and supportive. Overall ratings and not individual incidents of inhumane treatment would be the focus. Staff would need to know that, in principle, action on the basis of findings would be possible without adding unreasonably to their own workload and problems; that they would not be subject to unreasonable managerial censure or policing in the event of negative findings; and that interprofessional hostilities would not be instigated or fuelled as a result from a review of the humanity of a particular care setting.

It would probably not be practicable for an outsider such as a social researcher to be brought in to apply an inhumanity index. It would be too expensive for one thing, especially if the index were to be regularly applied and incorporate dimensions addressing professional practice which in my view would be essential. If used by 'insiders', these should not be nurse or other professional managers. It would be impossible for them to spend the time needed to observe ward level practice; thus the method might become corrupted or lose credibility. More seriously, it would prove immensely threatening and therefore probably quite counterproductive. Probably an inhumanity index would be a tool for peer review. Ward-level nurses, doctors or others might collect the data for appraising ward practices. This suggestion too is not without its problems: intra-hierarchical ones for ward-level nurses (even within a ward, there is a hierarchy of authority from the sister to the nursing auxiliary) and inter-professional tensions, whoever of the insider professionals gathers the data. Perhaps newcomers to the ward - newly-appointed nurses, junior doctors, nursing or medical students for instance - might spend their first few days using the notions of the inhumanity index as a guide for simply

observing a small number of patients, and feeding back their observations to the staff group as a whole. This could prove an extremely valuable learning process for the observers, as well as offering regular opportunities for systematic review of ward functioning amongst the whole group of ward staff.

Relatives' groups might offer yet another dimension. Wards could - by means of a booklet perhaps - inform newly-admitted patients and relatives about their principles and practices of humane care, and regular opportunities for joint discussion might serve a number of very constructive purposes in pursuit of maintaining standards. Relatives would have a forum for airing their views, including their own feelings of guilt and anxiety; opportunities for incorporating relatives into the life of the ward could be fostered; staff's awareness and understanding of non-professional perspectives and notions would be heightened. Of course this idea, too, is potentially rather threatening to staff; but that is not a good reason for failing to explore it in practice.

Some means of sharing the findings from applying an inhumanity index as between wards, between hospitals, even between regions would be valuable as a way of disseminating ideas about and experiences of securing good practice; and of seeking solutions to intractable problems. Visits and study days are obvious ways of doing this. Staff exchanges might be possible on a local basis. Wards found to be performing particularly well might be rewarded in some way.

Conclusion

Identifying the practical prerequisites to widespread local use of an index of inhumane treatment, and testing different approaches, would form a vital part of the development-work which I would like to see following up the research I have presented in this thesis. In 1984 in Britain, we know a good deal about what is wrong with long-stay geriatric care. I hope I have succeeded in beginning to develop a practical tool which will contribute to the pressing need to expedite ameliorative changes.

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APPENDIX A: Some characteristics of study patients

KEY

- * In Column 1 denotes the three strategic patients from each ward.
- (1) Patients' names have been changed.
- (2) Although I aimed to sample only those of 75 years or older, several patients were younger. Their ages had been inaccurately recorded in written records.
- (3) Refers to time since admission to study hospital, which in most cases coincides with time since admission to study ward. Norton is an exception: all patients had been transferred in from other wards or hospitals.
- (4) Only discharges and deaths are noted.
- (5) Researcher's opinion.
- (6) Researcher's opinion.
- (7) Researcher's opinion regarding patients' independent mobility in the ward. This included self-use of wheelchairs, zimmer frames etc.
- (8) Diagnosis as recorded in medical notes on the current admission to hospital.
- (9) Total number of observations.
- (10) Percentage of observations when the patient was alone.

CRANFORD: STUDY PATIENTS

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
ALMA PURBRIGHT	82	1 Day	Yes	No	Yes	Confusion, constipation, raised blood pressure	99	42.5
BERTHA CHARTERIS*	86	10 Days	Yes	Yes	Yes	Congestive cardiac failure, Anaemia, falls	109	31.9
HENRIETTA HOLDSWORTH*	90	18 Days	Yes	?	No	Aortic incompetence, congestive cardiac failure, immobility	99	45.7
EMILY FORMAN	82	> 1 Year	Yes	Yes	Yes	Stroke, fractured hip	102	39.8
DOROTHY GILLEY	84	20 Days	Yes	No	Yes	Senile dementia	73	65.2
BEATRICE BURKE	89	1 Year	No	No	No	Immobility, double incont- nence, confusion, emotional lability, sacral pressure sore, weak and wasted	79	57.1
MARIE HANDS	87	1 Year	No	No	No	Longstanding osteoarthritis	87	44.7
MILDRED DAVIS	82	> 3 Years	No	No	No	R. Hemiplegia, chest infection	88	50.6
ELSIE CORBETT*	84	> 3 Years	No	No	No	Fractured hip, sacral pressure sore	76	69.4
EMILY HOROBIN	90	> 4 Years	Yes	No	No	Senile Dementia,	104	38.0
CAROLINE ARCHER	92	8 Years	Yes	No	No	Myocardial infarction, left ventricular failure, rheumatoid arthritis, alcoholism	76	63.0

BRAMLINGTON: STUDY PATIENTS

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(4) OUTCOME	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
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ADA PARKER*	90	5 Days		Yes	?	No	Old fractured femur, for rehabilitation	87	37.9
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EVELYNE COLLERIDGE	79	5 Days	Discharged 14 days after admission	Yes	Yes	Yes	Holiday admission	36	40.0
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DOROTHY REECE	82	> 5 mths		No	No	No	Confused, diabetic, arthritic Incontinent of urine, social problem	66	67.6
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CARRIE CARTER*	78	> 1 Month		Yes	No	No	Demented, diabetic	68	60.3
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EDITH JOHNSON	72	> 1 Year		Yes	Yes	No	Contractions of knees, pressure sores	71	50.0
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BEATRICE WALLER	79	> 1 Year		Yes	No	No	Dementia, aortic valve disease	64	53.9
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MARGARET WILDER	92	> 5 Years		Yes	No	Yes	Confused, immobility following falls	65	61.0
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ANNIE McDONALD	100	> 5 Years		Yes	No	No	Fractured neck of femur	64	66.1
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DAISY PRINCE	85	9 Years	Died on 5th day of research	No	No	No	Parkinson's	22	61.9
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FLORENCE BATCHELOR*	91	14 Yrs		Yes	Yes	Yes	Stroke, Pulmonary embolism	71	67.1
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(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(4) OUTCOME	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
GERTRUDE ROLLINGS	84	4 Days	Discharged 4 days after admission	Yes	No	No	Chronic leg ulcer (rotating admission)	58	40.0
EVA BRAYFIELD*	82	6 Days	Discharged 14 days after admission	Yes	Yes	Yes	Uncontrolled diabetes, bilateral cataracts, atrial fibrillation	50	38.0
GLADYS HENTLEY	84	11 Days	Discharged 14 days after admission	No	No	No	Severe brain failure (rotating admission)	14	
FORENCE BUTCHER*	89	1 Year		Yes	Yes	Yes	Diabetes, osteoarthritis, social problem	97	64.0
ANNE ROUTLEDGE	72	1 Year		No	No	No	R. Hemiplegia	74	68.0
EMILY GRIFFITHS	96	> 4 Years		No	No	No	Confused, double incontinence rodent ulcer l. cheek	71	75.0
EVA WHITLEY	72	> 5 Years		Yes	No	No	Chronic Rheumatoid Arthritis	80	61.0
EMILY MANFIELD*	86	> 5 Years		No	No	No	Senile dementia, social problem	72	81.0
LILLY DUGMORE	95	6 Years		No	No	No	Cerebral arteriosclerosis, fractured femur	78	73.0
ETHEL DOWLING	78	> 2 Months		No	No	No	R. Hemiplegia, atrial fibrilla- tion, acute exacerbation of chronic bronchitis	86	71.0
HILDA SELLARS	72	Admitted on 3rd day of research		Yes	Yes	No	Parkinson's, transient ischaemic attack	84	45.0

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) * ALONE
LEONARD CULLEN	84	2 Years	Yes	No	No	L. Hemiplegia	64	55.6
CHARLES WATFORD	76	2 Days	Yes	No	Yes	Relief admission (old stroke)	55	73.5
ALFRED GRAFTON	75	7 Days	Yes	No	Yes	(Relief admission) Parkinson's, congestive cardiac failure, atrial fibrillation	66	66.1
CHARLES BAZELEY	79	> 3 Months	Yes	?	No	Parkinson's, fractured femur	58	54.0
CHARLES MARSH	78	> 6 Months	Yes	No	Yes	Parkinson's, depression, anaemia, ? uremia, faecal incontinence, schizophrenic symptoms	63	62.0
ALBERT SIMONS	83	18 Days	Yes	?	No	Chronic bronchitis, L. Hemiplegia, depression	60	56.9
JOHN MALIN	98	> 7 Years	Yes	No	No	Mild congestive cardiac failure, arteriosclerosis	65	52.7
JOHN EWING*	77	2 Years	Yes	?	No	L. Hemiplegia, Parkinson's	48	75.0
GEORGE BRENNAN	92	> 1 Year	Yes	No	No	Longstanding osteoarthritis, chronic bronchitis	66	47.2
JACK SATCHELL*	89	19 Days	Yes	Yes	No	Osteoarthritis (knees), obesity, incontinence of urine, chronic bronchitis, hypertension	61	55.8
HORACE BIRT*	84	Admitted on 6th day of research	Yes	Yes	Yes	Congestive cardiac failure, pernicious anaemia, iron deficient, mildly confused	39	45.1

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(4) OUTCOME	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
EDWIN HUTCHINSON*	88	>6 Years		Yes	Yes	Yes	None	85	85.5
ELIZABETH LUMSDEN	89	>5 Years		Yes	No	No	Old L. Hemiplegia, Incontinent	84	77.0
ELSIE MORONEY*	85	5 Years		Yes	No	No	Mild cerebral arteriosclerosis, double Incontinence, impacted faeces, social problem	80	62.5
ELIZABETH JENKINS	84	4 Years		Yes	?	No	L. Hemiplegia	87	58.4
JAMES GREVILLE	80	1 Day		Yes	?	Yes	No specific diagnosis (wife unable to cope)	95	58.5
LILLIAN BUZZARD	93	4 Days	Died 12 days after admission	Yes	Yes	No	Mild L. Hemiplegia, fall	52	48.8
ALICE LARKIN*	89	6 Days		Yes	Yes	No	Chronic venous insufficiency to lower limbs	93	32.9
ALFRED GREGORY	95	14 Days		Yes	Yes	Yes	No specific diagnosis (wife admitted to hospital)	86	72.6
MARGARET STOREY	78	>1 Year		Yes	Yes	No	R. Hemiplegia	96	48.2
FRED WRIGHTON	82	>2 Years		Yes	No	No	R. Hemiplegia	84	73.9
FRANK HARTWEIL	78	Admitted on 2nd day of research	Died 14 days after admission	No	?	No	Fall/Head injury, immobile since fall	78	66.1

NORTON: STUDY PATIENTS

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
FLORENCE WALPOLE	87	> 1 Month	Yes	Yes	No	Blind and slightly deaf	91	37.6
FLORENCE GIBBOURNE	83	> 1 Month	Yes	No	No	Confused	82	59.7
ELIZA WAINWRIGHT*	91	1 Month	Yes	Yes	No	R. Hemiplegia	104	32.6
CATHERINE TYMAN	93	> 3 Months	Yes	Yes	No	Impacted fractured femur, gross degenerative bone disease, varicose ulcers	80	50.6
DAISY THACKARY	86	> 4 Years	Yes	?	No	Fractured femur, epileptic	74	68.0
ETHEL BALDOCK*	94	> 3 Years	Yes	No	No	Senile dementia, social problem	74	60.3
GERTRUDE WOOD	81	> 3 Years	Yes	No	No	Urinary incontinence, social problem	81	66.2
CICELY MANSON	76	> 3 Years	No	No	No	Social problem, senile dementia, myxoedema	81	68.4
DOROTHY KENYON*	86	> 1 Year	Yes	Yes	Yes	Fractured femur, Paget's disease, varicose ulcer	66	77.0
DORIS RIDDELL	75	> 1 Year	Yes	No	Yes	Confused, senile dementia	76	68.6
DAISY WEST	80	Admitted on 2nd day of research	Yes	No	No	Chronic ulcer, L. Hemiplegia	71	59.7

DISTRICT: STUDY PATIENTS

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(4) OUTCOME	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
BEATRICE JAMES	80	>4 Years		No	No	No	Congestive cardiac failure	71	76.0
HETTY CHESTERTON	98	>5 Years		Yes	Yes	Yes	Double Amputee	76	54.4
BENJAMIN MCVICAR	78	>3 Years		Yes	No	No	Stroke, faecal incontinence, cerebral failure	73	65.1
GLADYS SKIPPER	79	>2 Years		Yes	No	Yes	Dementia	73	40.3
SELINA HOARE	85	>1 Month	Died 2 months after admission	No	?	No	Falls - ? cause	67	61.1
COSTA MAKRIS*	75	1 Month	Died 2 months after admission	No	No	Yes	Brain failure	84	77.0
BAROLD MILLWARD	85	2 Days	Discharged 19 days after admission	Yes	Yes	Yes	Acute over chronic bronchitis	84	44.0
ETHEL FERGUSON	78	2 Days	Discharged 14 days after admission	No	?	No	CVA, Long-term invalid	66	44.2
HARRY WILLIS*	95	1 Day	Discharged 23 days after admission	Yes	Yes	Yes	Severe Anaemia ? cause	87	54.7
FRANK CHAMBERLAIN	83	1 Day	Discharged 9 days after admission	Yes	?	Yes	Parkinson's, dehydration due to vomiting	57	62.8
FRED WAGSTAFF*	77	Admitted on 4th day of research	Discharged 25 days after admission	Yes	Yes	Yes	Chest infection	59	37.2

(1) PATIENT	(2) AGE	(3) TIME SINCE ADMISSION	(5) TALKS INTELLIGIBLY	(6) COMPOS MENTIS	(7) GETS ABOUT	(8) DIAGNOSIS	(9) NO.OBS	(10) & ALONE
MICHAEL O'MAHONEY	79	> 5 Months	Yes	Yes	Yes	L. Hemiplegia, diabetes	83	42.0
THOMAS WESTLAND*	82	13 Days	Yes	Yes	No	Depressed, pain in left hip, chest infection	106	40.7
PHYLLIS GOUDHURST	82	> 1 Year	Yes	Yes	Yes	Varicose ulcers, osteoarthritis, old fractured femur	93	61.9
ANN BROWN	97	5 Months	Yes	Yes	Yes	Debility	64	63.9
NORA MOGG	78	> 3 Years	Yes	No	Yes	L. Hemiplegia	77	42.5
MABEL STOCKTON*	88	> 2 Years	Yes	?	Yes	Social problem, cerebral arteriosclerosis	69	73.0
HILDA HAWTHORNE	88	> 2 Years	Yes	No	Yes	Anaemia, mental confusion, controlled congestive cardiac failure	107	61.2
MARY PEMBURY	80	> 2 Years	Yes	Yes	No	R. Hemiplegia	92	44.2
HAROLD MAYSTON	83	> 5 Years	No	?	Yes	R. Hemiplegia, Aphasia	70	61.2
DORIS MAXWELL*	86	> 2 Years	Yes	Yes	Yes	Amputation of leg, peripheral vascular disease, fractured femur	82	48.0

APPENDIX B: Sisters' Interview Guide

Introduction

I'd like to find out as much as possible about the ward, about the patients, about how you run the ward, about what sorts of problems you come across in your work and how you cope with them.

Hospital:

Ward:

Date:

No. sessions/duration:

Name:

Interview time:

1. About the ward's patients

You have _____ beds on this ward (?), _____ male and/or _____ female, and _____ beds in single/double/3-bedded sideways

Could you just remind me of some of the characteristics/things about the usual type of patient you get on the ward? (Prompts: age; average/range; diagnoses; sources and routes of admission; reasons for admission; throughput; bed occupancy; mental state; continence; incapacity; reasons for discharge/non-discharge, incl. transfer; discharge destination, transfer/home/death ...).

2. About the nursing care of patients

- 2.1. Is much of the nursing care what we might describe as basic (e.g. bathing, toilet, feeding and ensuring general care, comfort and cleanliness), or would you say that there is also quite a lot of technical nursing requiring special knowledge or skills? Examples:
- 2.2. Do you ever find particular patients difficult to manage and care for? Examples:

- 2.3. Do you find you can ever predict how things will turn out for a patient when s/he is admitted? Examples? (Find out how patients are categorized: by medical or nursing labels, social problems, etc.)
- 2.4. Do you see geriatric nursing as a specialty within nursing:
- 2.5. Do you (or your staff) ever get involved with therapy (e.g. physio-) with patients:
- 2.6. Any other comments re patients and nursing care of patients:

3. Organisational Factors

I'd like to move on to talk about some of the things which may affect the way you run the work on the ward: staff; anatomy of the ward; availability of resources, both physical and in the shape of other staff; standards of maintenance; hotel-keeping services to the ward; administration (and the bosses); and the way beds are managed.

3.1. Staff: Nursing

<u>Grade</u>	<u>FT/PT (hrs)</u>	<u>No.</u>	<u>How long on ward</u>
--------------	--------------------	------------	-------------------------

Learners: How many? How long on ward? How experienced?
Involvement of clinical teachers?

Are there enough staff? Of the right grades? Is (internal rotation/permanent staffing) OK? Or would another arrangement be better?

Shift time: What is the best and worst about these shift times from the point of view of running the ward?

3.2. Ward layout: good and bad points.

3.3. Resource availability: Besides the layout of the ward itself hindering/helping you, do you find that you have available all the physical resources and aids you need to do your work, e.g. special beds, lifting aids, technical equipment, facilities for occupying patients:

3.4. Availability of other staff: How many other staff are there who could be involved in caring for patients and whom you can call upon? Is that enough? (Prompts: OT, physiotherapy, speech therapist, social worker, dietician, chiropodists, volunteers?).

- 3.5. Are other services to the ward OK? (Prompt: x-ray, pathology, pharmacy, hotel-keeping: portering, physical maintenance, domestics, food, laundry, clerical?)
- 3.6. Administration and nursing administration: Do either of these lay down any definite do's and don'ts about the way you should run the ward? (Prompt: can you think of any decisions you have to make where you are expected to check things out with admin/nursing admin? Are there times laid down when particular tasks have to be done?)
- 3.7. Paperwork: Is there a lot of paperwork you have to do in connection with running the ward? (Find out about ALL paperwork, the rationale for it, who it's for and whether it's of any value).
- 3.8. Bed Use: Is there any policy regarding the way beds are used?
- 3.9. Bed Use: Planning - How does this affect the extent to which you can plan ahead?

4. Work scheduling, patients' daily routine and structure/process of interaction with other departments

Now, I'd like to ask you something about how you organise things on the ward.

- 4.1. Would you say that on the whole, you organize things:

from day to day
from week to week
longer ahead than one week
a mixture (elaborate)

- 4.2. What are the objectives towards which you work in organising the ward:

for patients

for staff

for yourself

- 4.3. Perhaps you could just describe to me, as you see it, how things are done during a typical day/week on the ward. (Prompt: Nursing organisation: deciding what work is to be done, nb limits to discretion, allocating to nursing staff, supervising, order of play/events (including visiting, rounds, case conferences). Nursing/other department interface: referrals to other departments; requests/instructions/communications from other departments, handling relatives - and any PROBLEMS in all of this.)

5. Interpersonal factors

- 5.1. Many people stress the importance of teamwork in the care of the elderly, whether in hospital or in the community. Would you say that you (and your nursing staff) feel you belong to a team? If yes, exactly who does the team consist of:
- 5.2. Structure of team: How does the team work? Where are the boundaries and how clear are they, between your role and that of doctors, therapists, social workers, etc.:
- 5.3. Authority and responsibility: Do you feel responsible/answerable for your own work to anyone (in the team):

YES/NO

If yes -

Who:

What does this mean for you in practice, e.g. how free are you to decide:

What care/medication/other treatment a patient needs?

What needs to be done to prepare for a patient's discharge?

How to deploy your staff?

Other

About the staff under you: How do you work things out with your deputy? (When both on together, and when deputy on alone.):

Do you allow/expect your other staff to make any decisions about patients without consulting you first:

YES/NO

If yes, examples -

If no, why not -

- 5.4. Any other comments on interpersonal factors? (Including: if you are not satisfied with the work of any of your staff, is there anything that you can do about it?):

6. Ward Performance

6.1. Objectives: How far do you feel able to achieve your objectives:

for patients:

for staff:

for yourself:

6.2. Problems: What prevents you meeting your objectives? Is there anything that might be done about this:

6.3. Judging performance: How do you judge when/whether you are doing a good job, within the limits we've already talked about:

6.4. Quality of care: What do you feel about the quality of care your patients receive? Could there be any improvement? How could this be brought about:

6.5. Efficiency: Do you think this ward is run as efficiently as possible, i.e. is the best possible use made of the available beds and expert staff:

6.6. Other: Any other comments about the ward, the patients, the hospital or anything else to do with your work:

APPENDIX C: Consultants' Interview Guide

Name: Hospital:

Date: Duration of Interview:

No./duration of
sessions:

1. The catchment area and the geriatric department: general

- 1.1. No. over 65's in district
- No. over 75's in district
- No. over 85's in district

Comments:

1.2. No. geriatric beds:

Type of beds:

Location(s):

Comments:

1.3. How do hospital facilities match up to DHSS/local norms:

1.4. Other health care facilities for the elderly, e.g. day hospitals;
outpatient clinics:

1.5. What, if any, sorts of changes or developments would you like
to see in the range, type and extent of health care provision for
geriatric patients in hospital?

1.6. Medical staff: How many, what grades, and how does the work of
the district divide up amongst them:

1.7. Admissions: What are the typical routes by which patients are
admitted to this hospital? (Find out numbers, processes):

Transferred in/other hospital:

From day hospital:

As GP emergencies:

From domiciliary visits:

Holiday admissions:

Waiting list:

Other and Comments:

- 1.8. Bed utilisation: Do you find there are any problems in striking a balance amongst the range of demands for beds? (Probe: blocked beds, inappropriate GP referrals, inadequate community based health and social support systems):

2. Nursing care of patients and quality of care

- 2.1. Expectations of sister: Could you tell me something about what you expect of a ward sister in terms of deciding on and carrying out the nursing care of your patients:
- 2.2. Judging performance: How do you judge when the ward sister is doing a good job:
- 2.3. To what extent do you feel your expectations are met on _____ ward? What do you feel about the quality of care patients on _____ ward generally receive:
- 2.4. (If not already emergent) Are there any particular problems - perhaps not all of their own making - that ward staff/sisters have to contend with? What shortfalls are there from ideal care:

3. Organisational Factors

- 3.1. Policy: Are you directly responsible for setting any general, or specific, policies and practices regarding how wards are run:
- 3.2. Other organisational factors: Do you have any views about how the quality of ward work is affected - in either a positive or a negative way - by the following:

Ward layout:

Availability of physical resources:

Availability of (nursing) staff resources:

Availability of (other) staff resources:

Hotel keeping services:

Administration:

Nursing Administration:

Shift system:

Availability of beds (in focal ward/elsewhere):

Availability of social services/other outside resources for care of the elderly outside hospital:

Anything else about the way the hospital is run/staffed:

Anything else about outside organisations/people:

4. Ward work processes, and structure and process of interaction with other departments

I'd like to explore in a little bit more detail something about the organisation of care of patients on ward _____.

- 4.1. Management of patients' careers: Once a patient has been admitted to ward _____, how do you typically take things from there? (Probe: referrals to other professionals, case review and who is involved, setting therapeutic/care goals, co-ordinating therapy/care, moving the patient on: worsening condition/death; no change; improvement/discharge; transfer out, etc. - who does what and why?):

5. Interpersonal factors

- 5.1. How much time do you actually spend on the ward in an average week:

- 5.2. Would you say that other staff besides doctors have some influence in making decisions about both clinical and non-clinical aspects of the management of care of individual patients? If YES -

Which staff:

What kinds of decisions:

Would you say these staff consist of a team:

Is there any overlaps with respect to who-does-what as between different members of the team:

Which - if any - of the staff working with patients do you see as being directly answerable to you and/or junior doctors for their work:

6. Efficiency

Do you feel that the care of patients on _____ ward is as efficient and effective as possible, given the constraints we talked about earlier? Are there any general or specific changes or developments you would like to see over the next 12 months? 5 years? What are the chances of these taking place:

Any other general comments:

APPENDIX E: RESEARCH DIARY

<u>1978:</u>	<u>February</u> ↓ July August September ↓ December	<u>Start of research</u> Literature review Access negotiations <u>Pilot Study</u> Analysis of pilot data Continuing access negotiations Feedback to pilot study hospital Final arrangements for fieldwork Fieldwork, <u>Norton</u> Feedback report Fieldwork, <u>District</u> Feedback report Fieldwork, <u>Moorhouse</u> Feedback report Fieldwork, <u>Branlington</u> Feedback report Fieldwork, <u>Shipton</u> Feedback report Fieldwork, <u>Eastwood</u> Feedback report Fieldwork, <u>Cranford</u> Feedback report Fieldwork, <u>Heathlands</u> Feedback report
<u>1979:</u>	January/ February February/ March April/ May May/ June June/ July July/ August September/ October November/ December	Analysis Preparation of publications Report for SSRC
<u>1980:</u>	January ↓	
<u>1981:</u>	January ↓	
<u>1984:</u>	June	Thesis completed

APPENDIX F: Some characteristics of the eight study wards

Cranford

This was one of two geriatric wards in a small general hospital, serving a mixed urban/rural catchment area. It was housed in an old building, and its 29 female beds were, with the exception of a single sideward, arranged in two long rows in a large dormitory area; a traditional 'Nightingale' ward. The day room had been built on later, and was reached from the ward by a short walk down a passageway, off which were located toilets, washbasins and bath. Twelve patients had been in the ward for more than one year at the start of the research.

Bramlington

This was one of three geriatric wards in a small general hospital and, like Cranford, the hospital served a mixed urban/rural catchment area. All the patients were women. The ward was housed in an old building, and divided into two wings. The right-hand wing had twelve beds. One was in a sideward, two were partitioned off from the remaining nine beds, which were arranged 'Nightingale' fashion in a single large dormitory. This wing housed the 'worse' patients: all were long-stay and confused. The wing had a single bath and two toilets. The left-hand wing of the ward had 20 beds. Eleven were in a single large dormitory, the remainder in two smaller dormitories which had been partly partitioned off from the largest area of the ward. There were two toilets and one bath, and the wing had its own day room, as did the right-hand wing. Twenty patients had been in the ward for more than one year at the start of the research.

Shipton

This was one of four wards in a geriatric unit which had been designed as a psychiatric unit. There were two single sidewards, and the remaining 32 beds were arranged in four-bedded bays located around the perimeter of the ward. A central area contained toilets and bathroom, ward kitchen and office. There was one very large day room which doubled as a dining room, and two small day rooms. At the start of the research, there were 14 patients in the ward who had been there for over a year.

Eastwood

This was one of five wards in a purpose-built geriatric block on the site of a large general hospital which served an essentially urban catchment area. The ward was of a standard design. Its 28 male beds were arranged in four six-bedded bays, with four single sidewards. The single large day room was near the entrance to the ward; the nurses' station and office at the opposite end. At the beginning of the research, eleven of the patients had been in the ward for more than one year.

Moorhouse

This too was a ward in a purpose-built geriatric unit, but away from the site of the general hospital. It had two wings, adjoining a central day room. The men's wing to the left had 16 beds (three of which remained unoccupied during the research). There were three bays having eight, four and two beds; and two single sidewards. There were three toilets a shower and a bathroom. The women's wing was of exactly the same design. Seventeen patients had been in the ward for more than a year when I began the research.

Norton

This ward was of exactly the same design as Eastwood. It was one of three wards in a purpose-built geriatric unit, located at some distance from the general hospital of the urban catchment area. One of the four six-bedded bays was occupied by men, the remainder of the ward's beds were for women. At the start of the research, eighteen patients had been in the ward for more than a year.

District

This ward was housed in a Victorian building having two wings. The lefthand wing had 16 beds for women; the right-hand wing had 15 beds for men. Each wing was of the 'Nightingale' type, subdivided by partitions into two dormitory areas. The women's wing had a day room; the men's wing had an area for sitting within one of the dormitory areas. Just seven patients had been in the ward for more than a year when I began the research.

Heathlands

Like District, this was an old building on the site of a geriatric hospital in the city. To the left of the entrance was a wide passageway where patients might sit, opening into the dining area. Beyond this was the day room. Turning to the right from the entrance, the bed area was reached. There were three four-bedded bays occupied by women, and two single sidewards. Beyond this was a seven-bedded dormitory for men. Fifteen patients had been in the ward for more than a year at the start of the research.

APPENDIX G: INHUMANE TREATMENT OF STRATEGIC PATIENTS

KEY

Σ obs	Total number of observations			
PI	Primary inhumane treatment)			
SI	Secondary	"	") see p66 for definitions
TI	Tertiary	"	"	
Total	Total inhumane treatment			

APPENDIX G: Summary Table, Inhumane Treatment of Strategic Patients

<u>MOST ALONE</u>				<u>MEDIAN</u>				<u>LEAST ALONE</u>			
MRS. CORBETT (£obs = 76)				MRS. HOLDSWORTH (£obs = 99)				MRS. CHARTERIS (£obs = 109)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
7	0	0	7	26	0	0	26	10	11	5	26
MRS. BATCHELOR (£obs = 71)				MRS. CARTER (£obs = 68)				MRS. PARKER (£obs = 87)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
5	2	0	7	13	3	0	16	25	2	0	27
MRS. MAFFIELD (£obs = 72)				MRS. BUTCHER (£obs = 97)				MRS. BRAYFIELD (£obs = 50)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
5	7	0	12	2	5	0	7	1	3	0	4
MR. EWING (£obs = 48)				MR. SATCHELL (£obs = 61)				MR. BIRT (£obs = 39)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
3	0	1	4	9	2	4	15	6	9	2	17
MR. HUTCHINSON (£obs = 85)				MRS. MORONEY (£obs = 80)				MRS. LARKIN (£obs = 93)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
0	0	0	0	2	0	0	2	37	12	7	56
MRS. KENYON (£obs = 66)				MRS. BALDOCK (£obs = 74)				MRS. WAINWRIGHT (£obs = 104)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
2	0	0	2	3	4	0	7	14	15	0	29
MR. MAKRIS (£obs = 84)				MR. WILLIS (£obs = 87)				MR. WAGSTAFF (£obs = 59)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
4	9	6	19	2	3	0	5	1	9	4	14
MRS. STOCKTON (£obs = 69)				MISS MAXWELL (£obs = 82)				MR. WESTLAND (£obs = 106)			
PI	SI	TI	Total	PI	SI	TI	Total	PI	SI	TI	Total
3	0	0	3	1	1	0	2	8	4	1	13
HEATHLANDS											

APPENDIX H: STAFFING LEVELS

		<u>Nos. needed*</u>	<u>Actual nos.</u>		
			<u>Average</u>	<u>Max.</u>	<u>Min.</u>
CRANFORD (29 patients)	Mornings	8	6.8	8	5
	Afternoons	4	5.5	7	3
	Evenings	5	3.6	6	3
BRAMLINGTON (32 patients)	Mornings	6	4.5	7	3
	Afternoons	4	4.3	7	3
	Evenings	4	3.4	4	3
SHIPTON (30-32 patients)	Mornings	8 or 9	6.7	10	4
	Afternoons	4 or 5	7.1	10	3
	Evenings	4 or 5	4.3	7	3
EASTWOOD (25-27 patients)	Mornings	?	4.2	6	3
	Afternoons	?	5.4	8	4
	Evenings	?	3.4	4	3
MOORHOUSE (25-29 patients)	Mornings	6	4.3	6	3
	Afternoons	4	6.3	8	4
	Evenings	4	2.9	4	2
NORTON (28 patients)	Mornings	6	5	6	4
	Afternoons	4	4	6	3
	Evenings	4	3	4	2
DISTRICT (27-30 patients)	Mornings	9	5.2	7	4
	Afternoons	6	5.3	7	3
	Evenings	5	3.6	5	3
HEATHLANDS (19 patients)	Mornings	4	4.2	7	2
	Afternoons	4	4.5	8	2
	Evenings	4	2.6	4	2

* From ward sisters' interviews